Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month wood land 17:25 1an 20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** General Hospital County If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. 8. (Mc) Howard Howard 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 15 M 2□ F 2/5-/4-0908 Usual Residence of Decedent Director Ma 10a State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other than many injury or other traumatic event, the Medicial Examinat man be notified at any injury or other traumatic event, the Medicial Examinat man be notified at 10d. Inside City Limits 1 Yes 2 No Director Columbia M9 Howard 10e. Street and Numbe 10g. Cltizen of What Country? 10f. Zip Code Good body 10131 Court 21044 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 MYes 2 □ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be harles Wood land 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/04/ · Woodland -Columbia, ud Wite 10131 Cour 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Na Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison 21. Signature of Funeral Service Licenses ara 300 Wabash Avenue Baltimore, Mu 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): signed by the at d be detached fo Part II. Other eignificant conditions contributing to death but not resulting In the underlying cause given In Part f. Records. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy Completed peen s hes After this certificata 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA uneral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. fnjury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as steted. 2 Medicel Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

841

State Registrar

Medicai

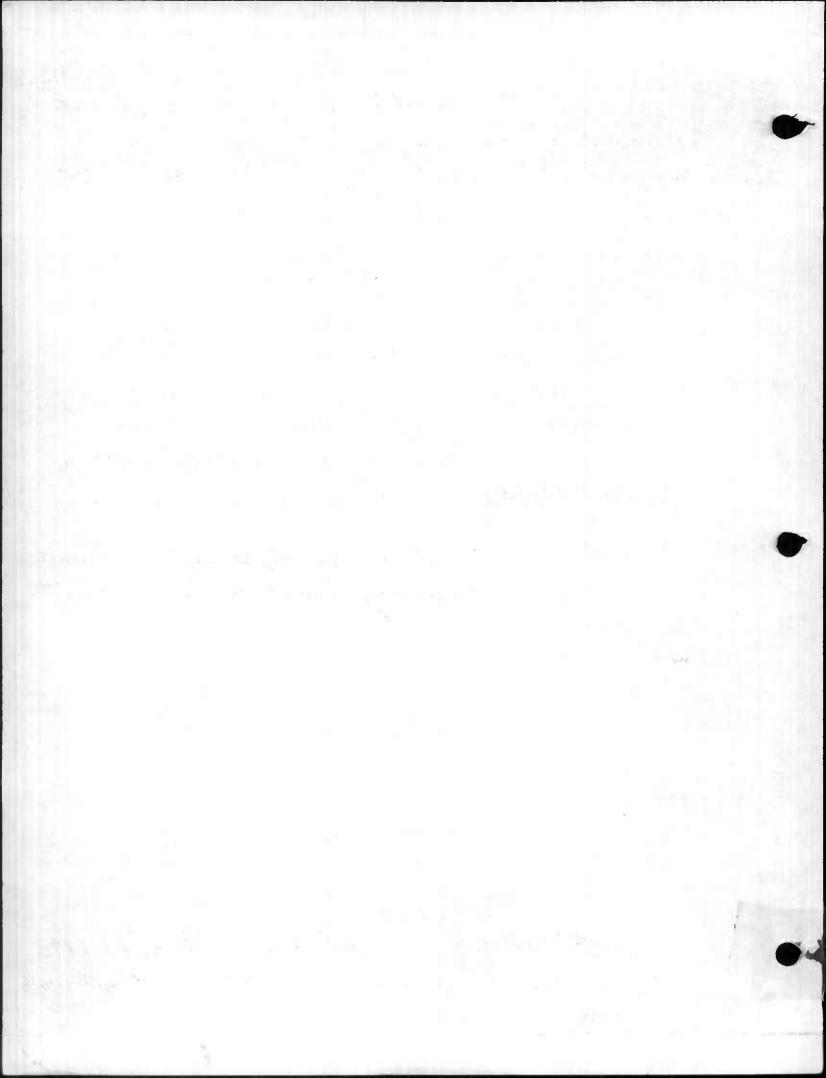
29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

All 6 ta h 1, M 0 4801 Dorsey Hall Dr Flicottity 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month WILBUR CARROLL WILSON, SR. Jan. 21, 1998 2:00 AM 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 623 Nautilus Avenue Baltimore Anne Arundel 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1X M 2□ F Months Days Hours Min 76 Yrs. 216-18-4384 Oct 1, 1921 Maryland Usuel Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Baltimore (Brooklyn Park) 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 623 Nautilus Avenue 21225 USA 12. Was Decedent Ever in U,S.
Armed Forces?
11 Yes 2 □ No
If Yes, Give
Year or Dates: WW 2 11 Maritel Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Retired Maintenance Montgomery Ward Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ms. Barbara Smith 641 Sunset Strip, (Daughter) Baltimore, Maryland 20b. Pleca of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State Crestlawn Memorial Gdns. 1/24/98 Marriottsville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fuperal Service Licensen Kevin E. 22. Name end Address of Fecility Ecker McCully-Polyniak Funeral Homes 237 E. Patapsco Ave., Balto., Md. 21225 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final Carcinoma 2 Mos disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atheroscientic Cardiovascular Disease 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Diabetes Mellitus - Type II 2 19 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 Tes 2 No 2 Accident

Examiner Box 68750 2 8 Records, P.O. 3 signed to d be det Division of Vital or Attending Physician: after death. Director: After this certifica

Physician

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "n any Injury or other traumatic event, the Med once.

Physician /Medical

Examiner

the Maryland

death

72 hours after

Baltimore, Maryland 21215-0020

/Medical

Physician/Medical Completed by Be Certification: To 29a. Certifier Medical

n 24 hours at Funeral Di To the Within 2 To the F 10 x

State Registrar

29b. Signature end title of cartifier

6 ☐ Could not be

29c. Licanse number

11 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29d. Dete signed (Month, Dey, Year) Jun. 22, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) E. Fort Robert Dart 901 tue.

Bultimore Cim

31. Dete filed (Month, Dey, Year) JAN 23 1998

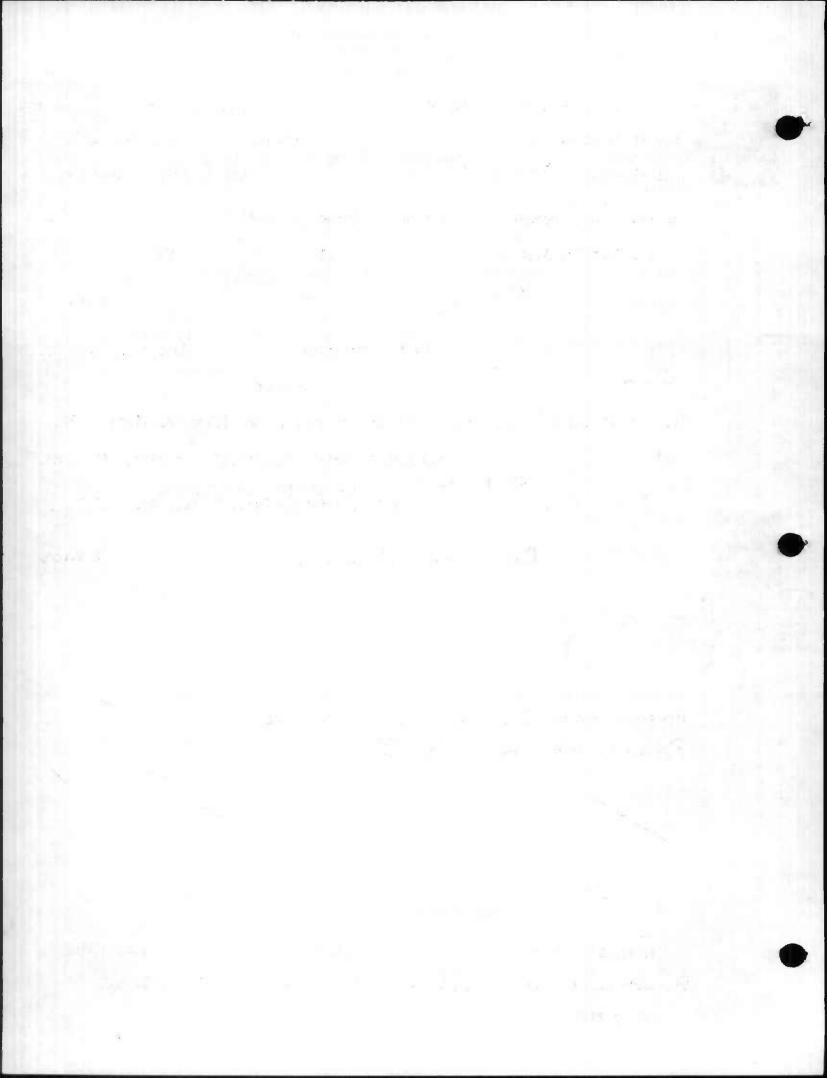
3 ☐ Suicide

4 Homicide

(Check only one)



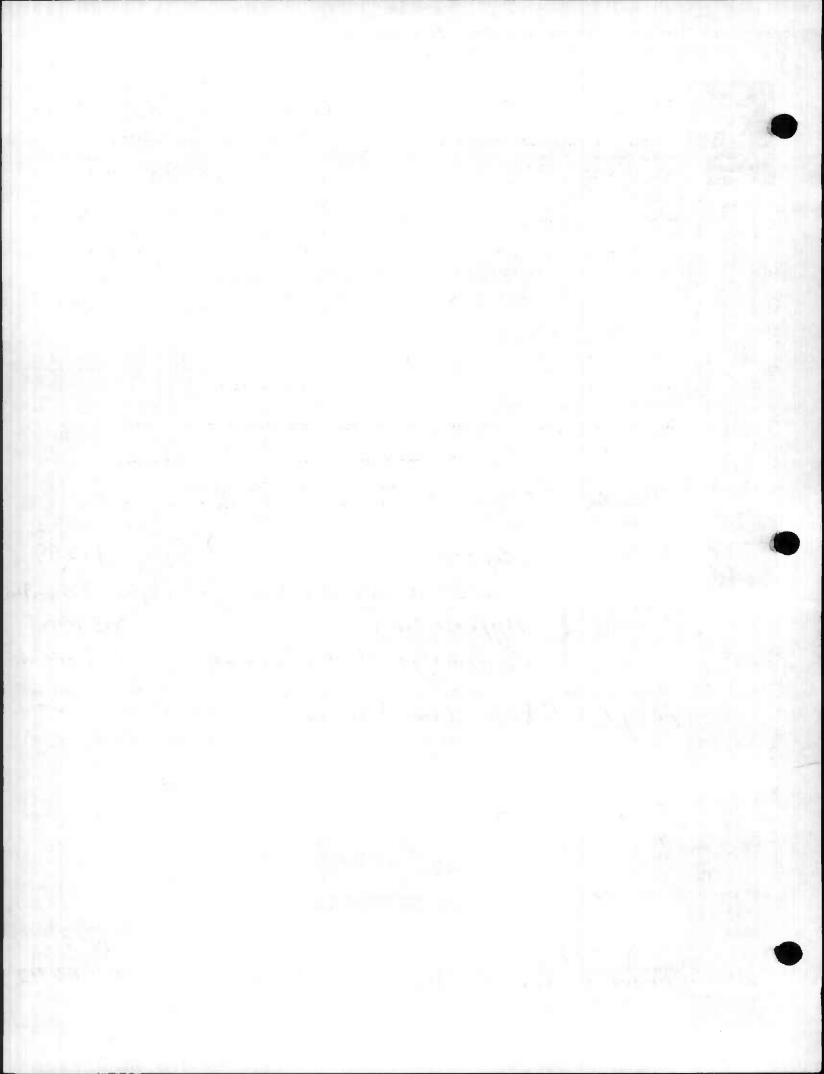
28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

ysician	1	. Decedent's Name (First, Middle, La	ast)			Death	2. Date of De		3. Time	of Death	
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		Washington Adver			If Under 1 Year		_				
eral	5		WINT ALL OF F	n yrs. last birthday Yrs.	Months Deys	Hours Min.	8. Date of Bi (Month, D.	av. Year	9. Birthplace (State Country) New York	or Foreign	
or	-	131 14 4058 Sual Residence of Decedent	/	3 Yrs.			Jan. 5	, 1925	New York		
	_	Oa. State 10b. County	10	c. City, Town or I	Location				10d. Inside (City Limits	
5	1									s 2∏No	
5		Maryland Montgo	nery	Takoma			Ţ				
Funeral Director	1	0e. Street end Number	#1100		10f. Zip Code	1.0		10g. Citizen of V			
4		7051 Carroll Ave	. #1108		209				d States		
Ine	1	1. Marital Status	12. Wes Decedent Eve Armed Forces?	r in U,S. 13	 Wes Decedent of I If Yes, specify Cub 	Hispenic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	D- 14. Raci	e - American Indian, k, White, etc.		
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d by		3 Widowed 4 Divorced	Year or Dates: 4	3-46				Орослу	White		
Completed		15. Decedent's E (Specify only highest gr		16e. Dec	edent's Usual Occupie kind of work done	pation during most of wor	kina	16b. Kind of Bu	siness/Industry		
hgu	-	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	re kind of work done DO NOT use retire	d)					
O		1.2		TV	Repair			TV Repa	air Shop		
Be	1	7. Father's Name (First, Middle, Las.	1)					, Malden Sumam	e)		
To		John Whipple				Marion	Reed				
1		19a. Informant's Name/Reletionship	(Type, Pnint)	19b. Me	iling Address (Street	t and Number or Ru	rai Route Numi	er, City or Town,	State, Zip Code)		
		Raymond C. Whip	ple Brothe	r 125	05 Swirl	Lane Bow	ie Marv	land 207	15		
	2	Oa. Method of Disposition		20b. Place of Disp	position (Name of rematory or other pla	Ton 20	Date		City or Town, State		
		1 Buriai 2 Seremetion 3	Ji tollioval liolii otato	, 1998	A 1	dria Virginia					
	-	4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice	4 1		litan Cre 22. Name end Addre			Alexand	iria virgi	nia	
	1	21. Signature of ratheral Service Lice	I Ken On		Robert E.	Evans Fu	neral E	lome, Inc			
		"Huenau d	siglen		16000 Ann	apolis Rd	. Bowie	Marvlar			
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplication that caused the	death. Do not e	nter the mode of dyi	ng, such as cardiad	or respiretory	errest,	Approximately Britary Britary	ate etween	
			1						Onset end	Deeth	
		mmediate Cause (Final	Sens	5.					1.12.	98	
	disease or condition resulting in death) a. Due to (or as a consequence of):										
ner		End Stage renal disease / dialysis 3 mon									
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	i	f any, leading to immediate couse. Enter Underlying	HYDOS	Leusia	20				SUS YP	925	
edicai	1	Sequentially list conditions, fany, leading to immediate course. Enter Underlying Cause (Disease or Injury that initiated events		115.10	, , , ,						
	ľ	esulting in death) Last		to (or es e conse	artery	10/500	000		x 2 U.	PONS	
3			d. Corm	wy	chije	Walk	*	101	-4.27		
Cia	-	Part II Other elsmificant condition	pontributing to double but a	ot requising in at	undadaina d	unn in Dard I	ook Di-	tobacca use s	atribute to the source	of doubt 0	
nysicia	F	Pert II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause gi	ven in Pert I.			ntribute to the cause		
y Physician/M	F	Pert II. Other algnificant conditions	contributing to death but n	ot resulting in the	underlying cause gi	ven in Pert I.		tobacco use co		of death?	
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edical Certification: To Be Completed by	2	25. Wes case referred to medical examiner? 1	Hospital: 28a. Dete of Injury (Month, Day Ye) 28e. Place of Injury building, etc. (3) nyalcian: To the best of milner: On the basis of example and menner steted	2 ER/Outpati 28b. Time Injury At home, farm, so Specify) by knowledge, det amination and/or continued to the second of the se	ent 3 DOA Of	26. Plece of Deather: 4 Nursing Hry et rik? 1 Yes 2 No	24a. Waperl 24a. Waperl 1 □ 24b. (Check only) 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed? Yes 2 No one) Idence 6 Oth how injury occurs (Street and Numbown, Stete) c cause(s) end me, date and place, and all all all all all all all all all al	3 Probably 4 24b. Were autops eveileble prior completion of deeth? 1 Yes 20 er (Specify) red er or Rural Route Number or Rural Route Number as stated, and due to the ceuse of Month, Dey, Year)	findings to ceuse No mber,	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Dey 18, Helen Marie Winkelman Jan. 1998 1:40 AM /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Gilchrist Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1943 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** 1□M 2XF Deys 220-40-7204 Maryland 54 Yrs. Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. fnside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter deeth with tha Merylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinat must be notified at 1 ☐ Yes 2 No Director Baltimore Freeland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21504 North Ruhl Rd. 21053 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Roger Smith Violet B. Grissett 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Louis M. Winkelman/Husband 21504 North Ruhl Rd., Freeland, MD 21053 20b. Place of Disposition (Neme of Service) Jan. 19, Vorktowne Caskets, Inc. Jan. 19, Cremation Service 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) York, PA 17404 22. Neme end Address of Fecility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or mant failure. List only one cause on each line. Onset end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting In death) /Medical metastatic concer 6 month Examiner Due to (or es e consequence of) Examine physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed paga 2 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Hospice 1 Yes 2 No After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 3 Suicide 8 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital within 24 hours e To the Funeral Complataly filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated. 29a. Certifier 29b, Signature and tipe of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A - R. Toy G-BMC 6201 N-C N-Charles St. Balto Md. 21204 Month, Day, Year)
JAN 2 3 1998

32. Registrer's Signature

the Davidson-Randage

DHMH 16 Rev 6/95

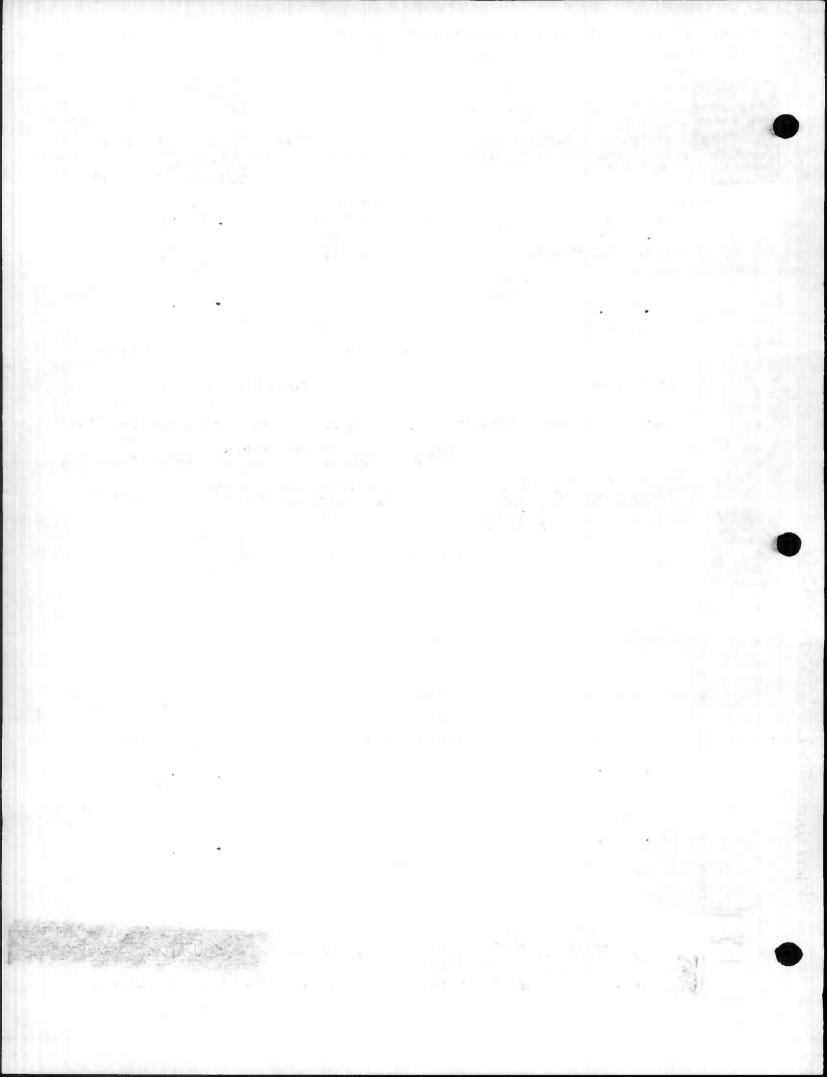
State

Registrar

31 Date filed (Month

1400

telen winkelman



Box 68760, P.0. Records, Vita of Division

WILDASIN Attending

To the Hospital or Att within 24 hours after di To the Funeral Direct completely filled in by State

Director: After this in by the funeral

death.

Certification:

Medicai

27. Menner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

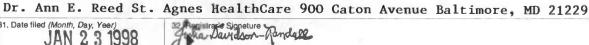
4 Homicide

31. Date filed (Month, Day, Yeer) JAN 2 3 1998

29b. Signature and title of certifier.

5 Pending investigation

6 Could not be determined



28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Injury

28c. Injury et Work?

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29c. License number

D41843

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

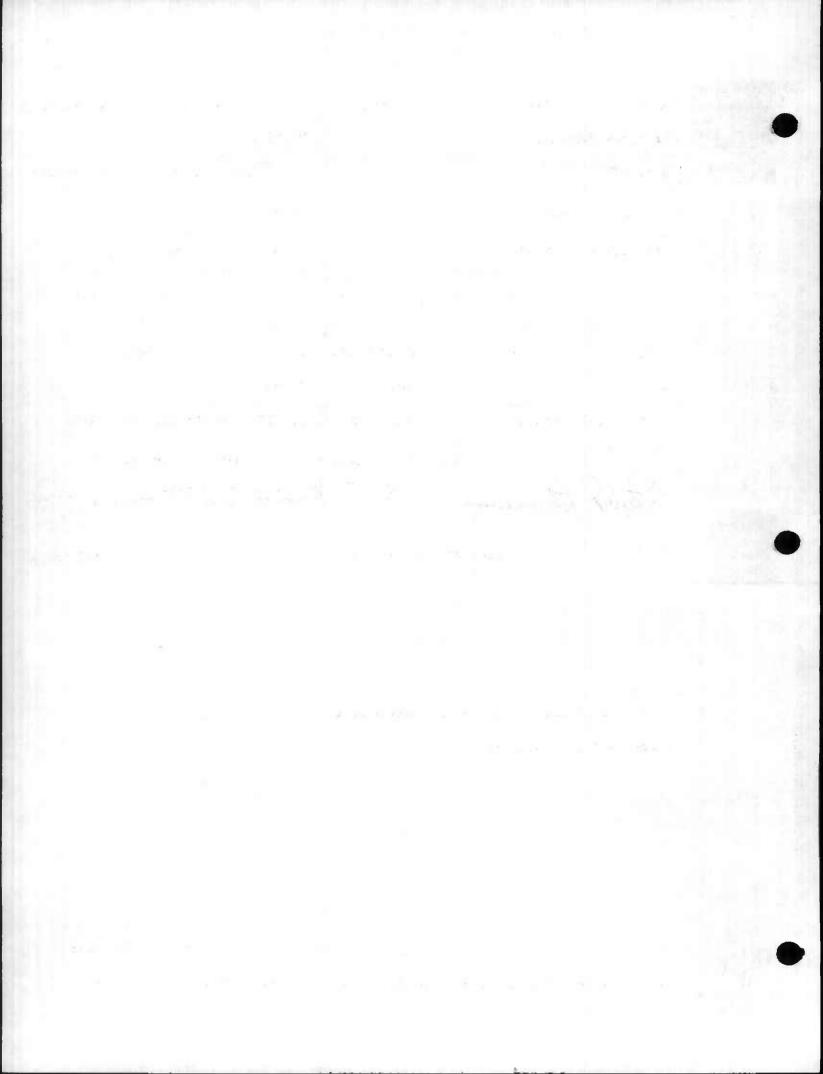
29d. Date signed (Month, Dey, Yeer)

January 20, 1998

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

28a. Date of Injury (Month, Day Year)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 4b. City, Town, or Location of Death WATKINS albert 2045 /Medicai 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Deaton nursing Home 6. Sex 10 M 2□ F 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funerai** Days Yrs. 216-16-0801 Usual Residence of Decedent Director MAY 31-1924 YARULAND. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2□No Directo ARY And none 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Ave USA 21217 1301 W. Lalayette Funerai 12. Was Decedent Ever In U.S.
Armed Forces?

12. Yes 2 \(\sum \) No
If Yes, Give
Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced 100 American 16b. King of Business/Industry Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 1216 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Evelyn WAIKINS 19a.) nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ma ral Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health ar Important: if item 27 is. any injury or other traus Orald Watkers - Son Stafford Vinginia 22554 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Tarreson Fores avings mill, md. 22. Name and Address of Fecility 21. Signet re of Funeral Service Licensee) Ancy m. WACACE Funeral Securio Per Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hearly fluire. List only one cause on each line. 3405 W. FRANKLIST St. BAStimine, Me 21229 Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting to death) /Medical Examiner ARTERIO SCLERO TE CHROID VASCULAR Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest Due to (or es e consequença of): physician s the burie Due to (or es e consequença of) 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Nnknown 1 ☐ Yes 2 ☐ No Preumonia þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? NEO PLASH COASTRO INTES TINAL BLEED/DESOPHAGEAL 1 ☐ Yes 220No 1 25. Wes case referred to medical exeminer? Be 28. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manper of Death 28d. Describe how injury occurred 5 Pending investigation Naturet 2 No 2 Accident eftar death 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. To the Funer completely fi (Check only one) 29b. Signeture end title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) DO 1346 Jan 22 51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 61 South CHARLES

State Registrar JAMES P.G. FLYUN

LUD GEATON SPECTIALTY

HOSPITAL

BACTIMORE

21230

DHMH 16 Rev 6/95

KON HAMON C. 216 16-6501 X 73 May to 18 se Shiref and Holy and your 1500 be supayed the After Americant - Bake the charte same Shiftens singer 235 4 I may my white the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth

If Under 1 Yeer

Deys

1 Yes 2 No Specify:

Months

Hagerstown

10f. Zip Code

7. Age (In vrs. lest birthday)

10c. City. Town or Location

99

Month

4b. City, Town, or Location of Deeth

Boonsboro

Hours

21740

Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 24 Hrs.

January

8. Date of Birth (Month, Dey, Year)

Nov. 24,1898

3. Time of Deeth

Birthplace (Stete or Foreign Country)

West Virginia

10d. Inside City Limits

1 X Yes 2 No

9:31 AM

13, 1998

4c. County of Deeth

10g. Citizen of Whet Country?

16b. Kind of Business/Industry

14. Rece - American Indien, Bleck, White, etc.

white

USA

Washington

1. Decedent's Name (First, Middle, Lest) **Physician** Maude Belle Ambrose /Medical 4a. Fecility Neme (If not institution, give street end number) Examiner Reeder Memorial Home 5. Social Security Number Funeral 1 □ M 2 🗓 F Director 214-09-7034 Usuai Residence of Decedent death with the Maryland show 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Exportent must be notified at Director Maryland Washington NAME: Mande Belle Ambrose Baltimore, Maryland 21215-0020 10e. Street end Number 346 S. Potomac Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give 1 ☐ Never Married 2 ☐ Married þ 3 X Widowed 4 □ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 end 2 should be filed within 7 Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "n any Injury or other trearmetic event, I'm Men 2008. Elementery/Secondery (0-12) 6 17. Father's Name (First, Middle, Last) Be Newton E. Kidwiler 2 20a. Method of Disposition 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Forteral Service Licenses **Physician** Immediete Cause (Final diseese or condition resulting In death) /Medical Examiner Examine The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Box 68760, physician Physician/Medical ettending p o ed by the deteched Records, P. signed I þ Completed s certificete hes lirector, page 2 director, 25. Was cese reterred to medical exeminer? Be Hospitel: P 1 Yes 2€ No Certification:

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) housewife 0 her own home 18. Mother's Neme (First, Middle, Malden Surneme) Ida E. Moore 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia L. Barger - daughter 205 Devonshire Rd., Hagerstown, Maryland 21740 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 X Buriei 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 1-16-98 Hagerstown, Maryland Name end Address of Fecility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 imu 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart teilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Cereto varales teciden ten his Due to (or es e consequence ot): Neute Myocardo w hy Due to (or as e consequence of): Anterio relevatio Cardiovarance Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Onknown Heart Congentin 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 19 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner ot Deeth 28b. Time ot Injury 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 1 BNaturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1. Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2. Medicat Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) -tom mo D(8019 Jan 13, 1998 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

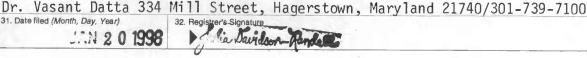
Division of Vital or Attending Physician: this funeral death. ector: by the t Direct lin by th filled 24 hours within 24 hor To the Fune completely fi

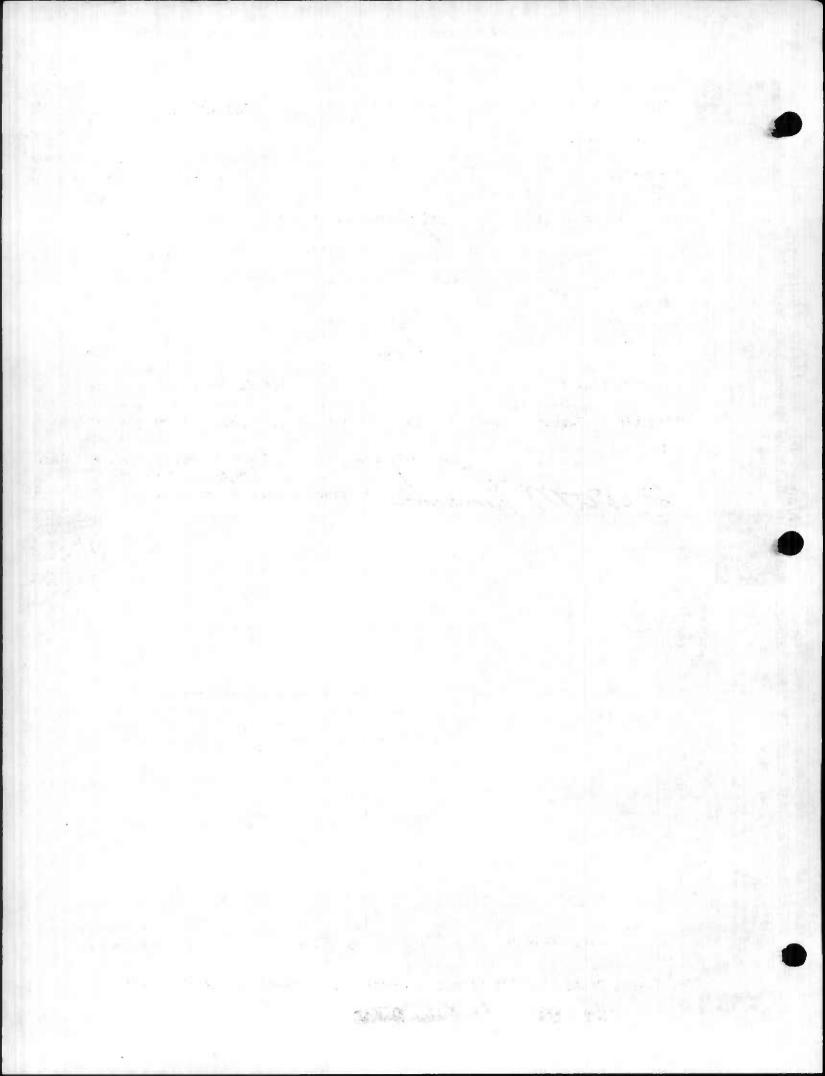
State

Medical

JAN 2 0 1998 Registrar

31. Date filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3 Time of Death

Physician
/Medical
Examiner
-

Funeral Director

with the Merylend 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "netural", or itema 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Director MARYLAND ALLEGANY CUMBERLAND 10f. Zip Code 10e. Street end Number 21 NORTH ALLEGANY STREET 21502 death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. nt: If item 27 Is marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 +HOUSE KEEPER 17. Father's Name (First, Middle, Last) Be CHARLES A. ADONIZIO SR. 19a. Informent's Name/Relationship (Type, Print) DR LEROY T. AGOSTINI SON other 1 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State Injury or permit. Page Depertment of Important: If any Injury or 4 Donation 5 Other (Specify) EMTOMBMENT SUNSET MAUSOLEUM JAN 6 1998 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME emb **Physician** /Medical Immediate Ceuse (Final e. AORTIC STENOSIS diseese or condition resulting in death) Examiner Due to (or as e consequence of) Examiner b RHEUMATIC HEART DISEASE physiclen end the buriel-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): certificate be execu S/P AORTIC VALVE Box 68760, Physician/Medical Due to (or es a consequence of): 98 ettending f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the page 2 should be deteched Division of Vital Records, P.O. ANEMIA, HYPOPROTHROMBINEMIA þ Completed this certificate director. 25. Wes cese referred to medical examiner? Be MARY AGOSTINI 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA illed in by the funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death Funeral Director: 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signature a nd title of certifier 29c. License number D 20258 15

1. Decedent's Name (First, Middle, Last) 3 1998 JANUARY 7:20 AM MARY ANN AGOSTINI 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CUMBERLAND ALLEGANY MEMORIAL HOSPITAL & MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) 6 Sex Months 1 M 2 F 86 Yrs. 219-44-2470 NOV 16 1911 PA. Usual Residence of Decedent 10d. Inside City Limits 1 Ves 2 □ No 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry HOUSE KEEPER 18. Mother's Name (First, Middle, Maiden Surneme) PHILOMENA ADDONIZIO 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 10001 SHINNAMON DRIVE S.W. LAVALE MARYLAND 20c. Location - City or Town, State CUMBERLAND MARYLAND 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death 5 YEARS 20 YEARS 5 YEARS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2. No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piace, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) usliesta 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SURESH SHRESTHA M.D., MEMORIAL HOSPITAL, CUMBERLAND, MD 21502 THO MITTICE SHOWING BUILD

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State

The last 130 7 64

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth

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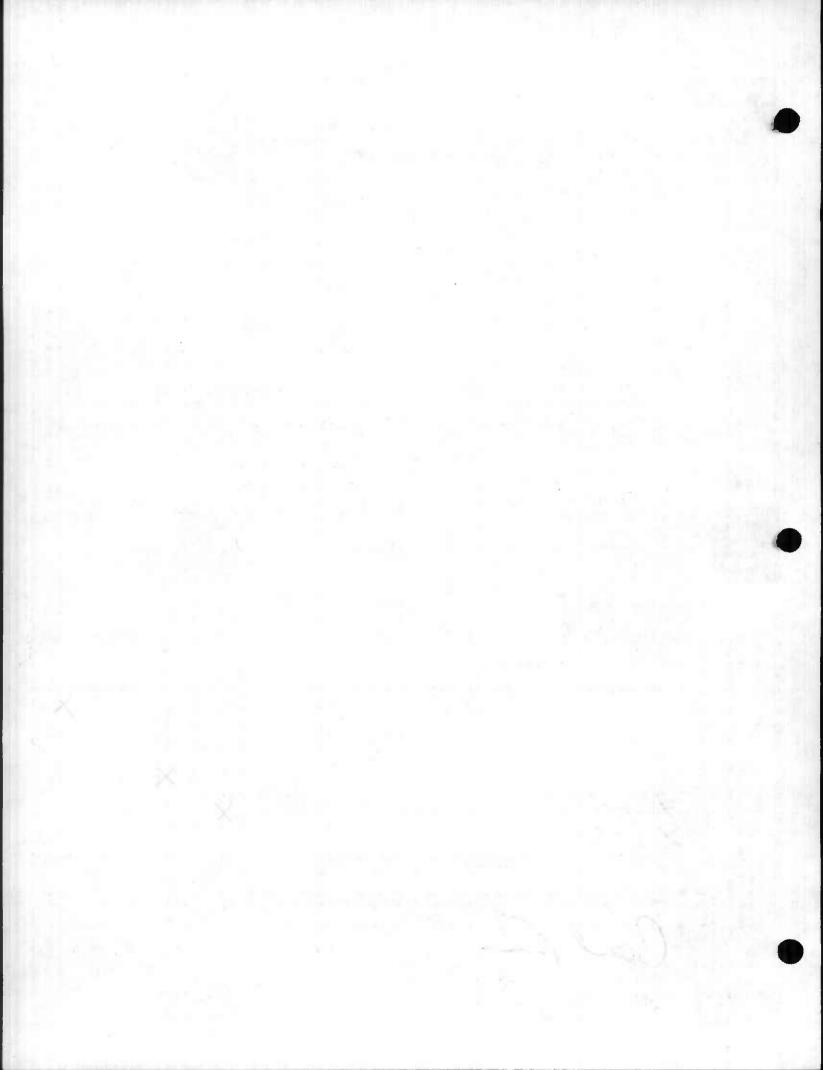
1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** PASQUALE PATSY JANUARY 10 1998 Year ALGIERI 11:25 AM /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 515 SHERIDAN PLACE ALLEGANY If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthplace (Stete or Foreign Country) Days Months 100 M 20 F 79 Yrs Director 077-09-3238 MARCH 30 1918 NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Expression result be notified at 10d. Inside City Limits MARYLAND Director ALLEGANY CUMBERLAND 1 Ves 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 515 SHERIDAN PLACE Funeral death 21502 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other than "naturel", or Ita 1 ☐ Never Married 2 ☐ Married 1√TXYes 2 No If Yes, Give τ.π. 21215-0020 1□ Yes 2√2 No Specify: Specify: þ 3√Widowed 4 Divorced Yes, Give WW11 WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) POSTAL SERVICE & Elementary/Secondary (0-12) College (1-4 or 5+) MILITARY AND U.S. POSTAL SERVICE MILITARY 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme, Itam 27 is marke other treumatic 2 GENNARO ALGIERI MARGARET COZZETTO permit. Pages 1 and 2 shoul Department of Health and Ma Important: If Itam 27 is mark any Injury or other treumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 35 MOCKINGBIRD LANE RIDGELEY, W.VA. 26753 CHARLES WILLIAM ALGIERI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) HILLCREST CEMETERY JAN 13, 1998 CUMBERLAND MARYLAND 21. Signature of Funera 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND det the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION 1 MONTH Examiner Due to (or as a consequence of): HYPERTENSIVE CARDIQ VASCULAR HEART DISEASE The lew requires that the death certificate be executed buriel-transit UK YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in death) Last pue Due to (or as e consequence of): P.O. Box 68760, physician Physician/Medical the Due to (or as e consequence of): use as Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. deteched 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy performed? peen hes certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Yes 2□ No Hospital: Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) this 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division After 5 Pending investigation Natural 2 Accident after death Director: A 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide filled in I To the Hospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) D 09157 JANUARY 10, 1998 9 nd address of person who completed cause of death (Item 23e) (Type, Print) DR. PAUL SNOW 124 nus WEST 3rd STREET CUMBERLAND MARYLAND 21502 32 Hegiefrar's Signature State

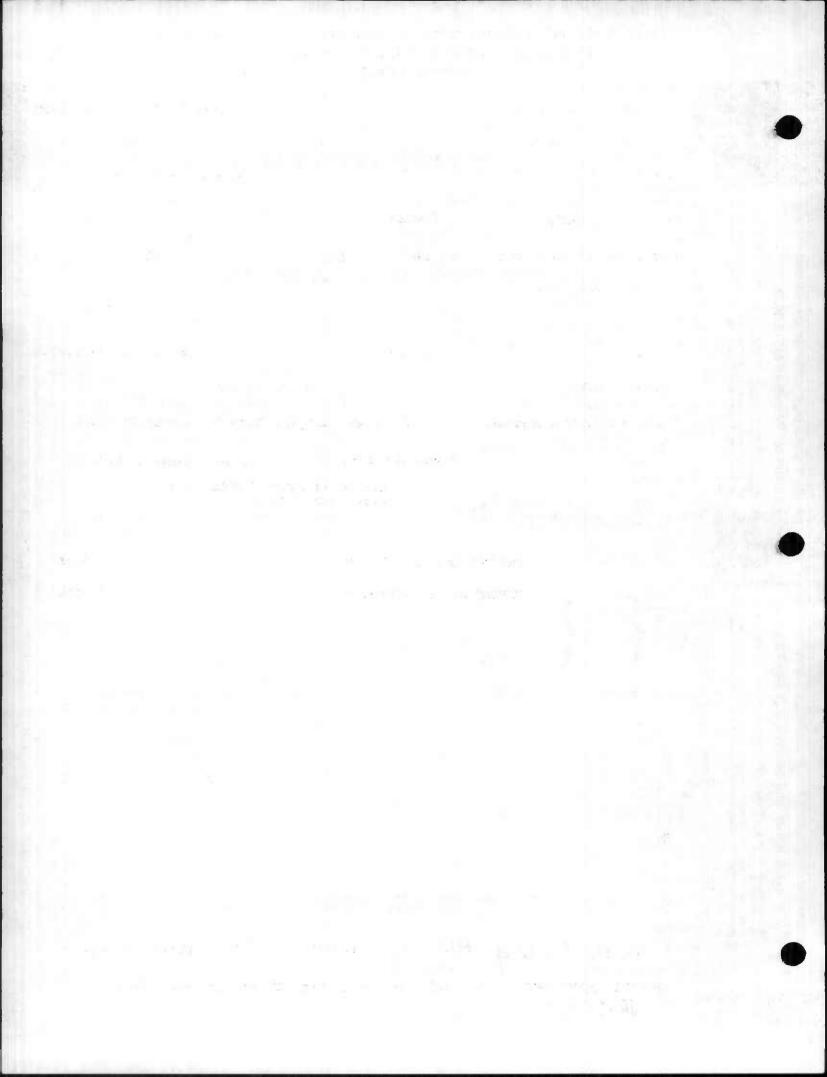
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Registrar



State of Maryland / Department of Health and Mental Hygiene 98 01510

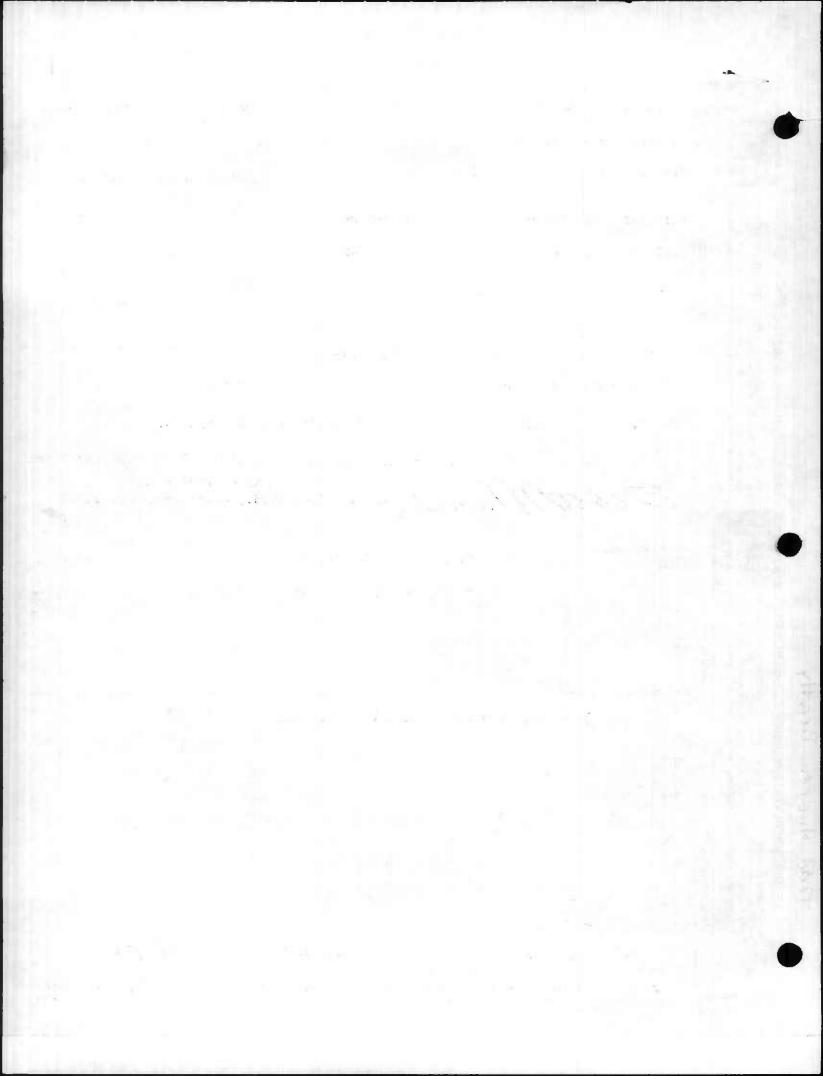
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tor		Sacred Heart H	ospital					Cumberla	and	Alleg	any		
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ris m traum		19e. Informent's Name/Relationship	(Type, Print)		19b. Ma	iling Addres	s (Stree	et end Number or Rurel Route Number, City or Town, Stete, Zip Code)					
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2		29b. Signeture end title of certifier		118		29	c. Licen	se number		29d. Date signed	(Month, D	ey, Year)	
		M. M.C. C. 30. Neme end eddress of person who	completed caus	M1)	m 23e) (Type	e, Print)	D44	712		JANUARY	9 19	98	



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4-			Cei	rtificate of	Death		Reg. No.	0 01511					
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Physician /Medical	Todd Andrew BEAT	ΓY				Janvery	13	1598 0018					
Examiner	4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town	n, or Location of Dea	h 4c. County	y of Deeth					
	Washington County	y Hospital			Ha	gerstown	W	ashington					
Funeral Director	5. Social Security Number 6. Sec. 219-86-2444	7. Age (In yrs. 37	last birthdey) Yrs.	If Under 1 Year Months Deys		Min. 8. Dete of Bi (Month, Di Dec. 5	ey, Yeer)	9. Birthplece (State or Fore Country) Virginia					
2	Usual Residence of Decedent												
show of at	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limi					
28a-1 notifie	Maryland Washing	gton	Наде	rstown				1⊠Yes 2□N					
r items 23a or 28a4 shorter must be notified.	10e. Street end Number 803 Maryland Aver	nue		10f. Zip Code 21740			10g. Citizen of USA	Whet Country?					
by	11. Marital Status 1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decadent of f Yes, specify Cub 1☐ Yes 2☐No		n? (Specify Yes or No Puerto Rican, etc.)		ca - American Indian, ck, White, etc.					
"natural", adral Eval	15. Decedent's Edi (Specify only highest grad	ucation	16e. Deced	dent's Usual Occu	pation	f working	16b. Kind of B	usiness/Industry					
and Marial Hygiene end Marial England in marked other than "natural summatic event, the Medical To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire ctarian	UIEI	ary on officer	correct	ional institu					
d other event,	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden Suman	ne)					
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traumetic	19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coo												
27 is	Kay F. Beatty - 1	nother	111	06 Glens	side Av	e., Hagers	stown. M	ld. 21740					
other other	20a. Method of Disposition	20b. l	Placa of Dispo	sition (Neme of netory or other pla		Dete		- City or Town, State					
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Andrew Beatty



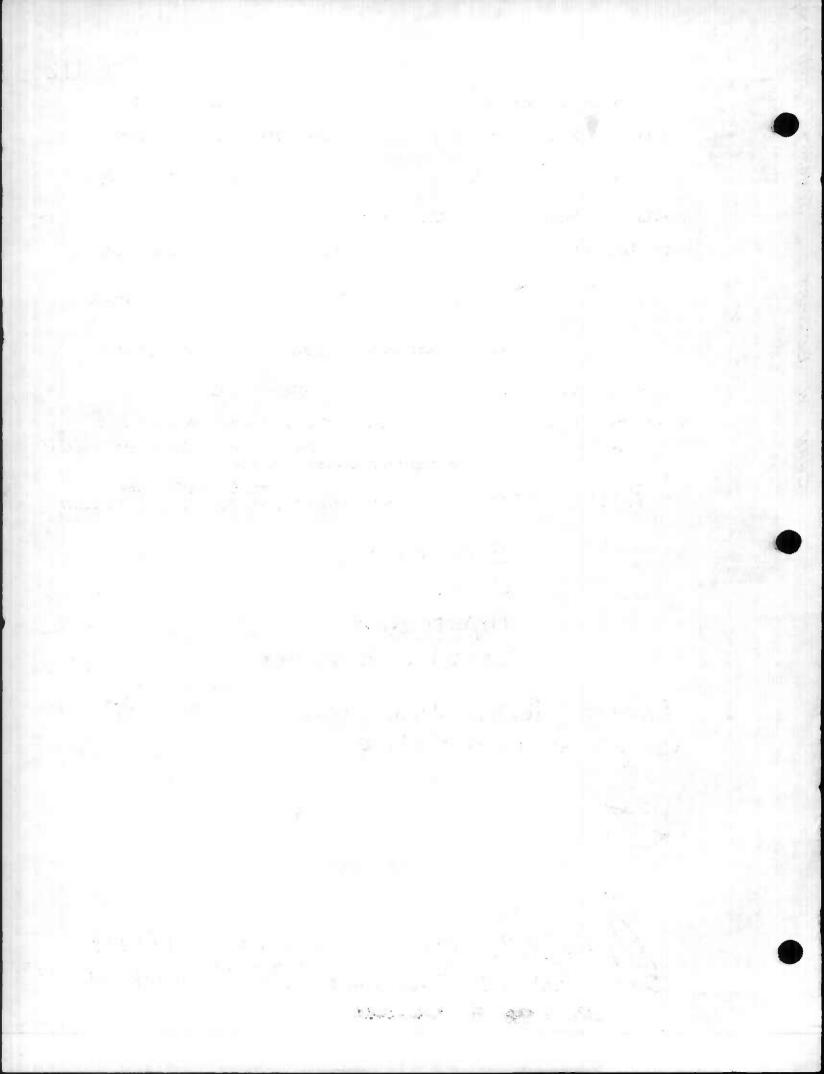
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 7, Day 1998 Year **Physician** John William Bossert 745 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Marys If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign
Country) Funeral Days Months 18-M 2□ F Director 212 38 8195 Usual Residence of Decedent 79 July 30 1918 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumstic event, the Mucical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2027 Circle Court 20685 United States 'neturei', or items 23e Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No
If Yes, Give
Year or Dates: Ret Maryland 21215-0020 1 Yes 2₺No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other treumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) mechanical engineer US Dept Navy 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be P John Wm. Bossert, Sr. Clare Nissel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Teresa Bossert- wife 2027 Circle Ct. St. Leonard Maryland 20685 altimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) Jan 8, 1998 20a. Method of Disposition 20c. Location - City or Town, State Alexandria Virginia 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ncephali **Examiner** Due to (or es a consequence of): Completed by Physician/Medical Examiner ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, MSra certificate be Due to (or as a consequence of): DBOVDER P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco usa contributa to tha causa of deeth? à 2 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Ulcer Disease Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The 1 ☐ Yes 20 No ete 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: All Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 28b. Time of 28d. Describe how Injury occurred Aftert 1. Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner as stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated. Medicai 29a. Certifier (Check only onel 29b. Signature and the of certifier 29d. Date signed (Month, Dey, Year) mD 15+1 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) , mD 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature Jali Stwolor Re JAN O Registrar

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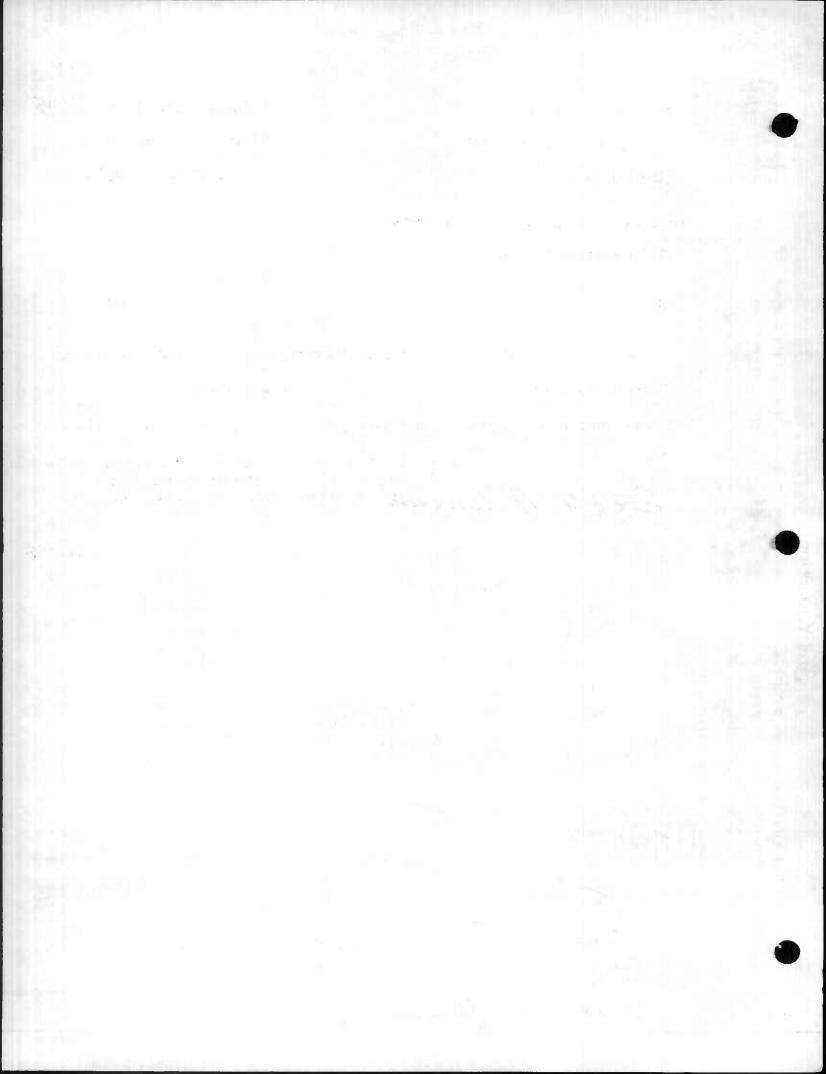
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State of Maryland / Department of Health and Mental Hygiene 8

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Physician Medical Examiner Manager Death Constant of Death		- 40260		"Sout	711 Min	nu					Md.	21740		
The dical Examiner The di	200			23a. Pern. Entar tha disaase, or com shock, or haart failura. List only	plications that caused the daa ona causa on each lina.	ith. Do no	t anter the moda of dy	ylng, such es cardia	c or raspiratory	errest,	1	Intarval Batween		
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State J. Data mad (mornin, Day, 1981) 32. Registrates Signature				31 Data filed (Month Day Year)	32 Panistrada Sta	of C		1111-0		The state of	ve	1217/2		
Registrar JAN 00 998 Julia Daurdina Thomas Co				JAN 08	1998 Auha	Danis	D. 2.00			U		1 /		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Month **Physician** 1410 4b. City, Town, or Location of Death Robert O'Neal BOND /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 12 M 2□ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. Director Feb.28,1935 214-32-4418 62 Maryland Usual Residence of Decedent tha Maryland 10a State d 2 should be filed within 72 hours efter daath with tha Manylan th and Mantle Hyglane. 7 Is marked other than "heture!", or items 23a or 28a-1 show traumatic event, the Medical Experiment mast be notified as 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21926 Jefferson Blvd. 21783 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Transport Driver Petroleum Product 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 Forrest M. Bond, Sr. Violo V. Itnyre permit. Pages 1 and 2 sh. Department of Health and Important: If item 27 is ma-any injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn A. Bond, Sr./Son 11037 Hopewell Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Jan.8,1998 Hagerstown, Maryland 21. Signature of Fa neral Service Licen 22. Name and Address of Facility Osborne Funeral Home 425 S.Conococheague St.Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lature. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Louis Examiner Due to (or as a consequence of) Examiner attanding physician and for usa as tha burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): as t Division of Vital Records, P.O. the s Part ff. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 PYes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? paga 2 should Completed 24a. Was an autopsy After this certificata has been performed? 1 ☐ Yes 2 ☐ No 1 Yes 24 No Be 25. Was case referred to medical 26. Plece of Death (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 → No 28c. Injury et Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury daath. 1 Yes 2 No i or Attend aftar daath Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral D JEC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical complataly (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

who completed cayse of death (Item 23a) (Type, Print)

32. Regist it's Signature

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State Registrar 30. Neme end address of person

31. Dete filed (Month, Day,

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Year)

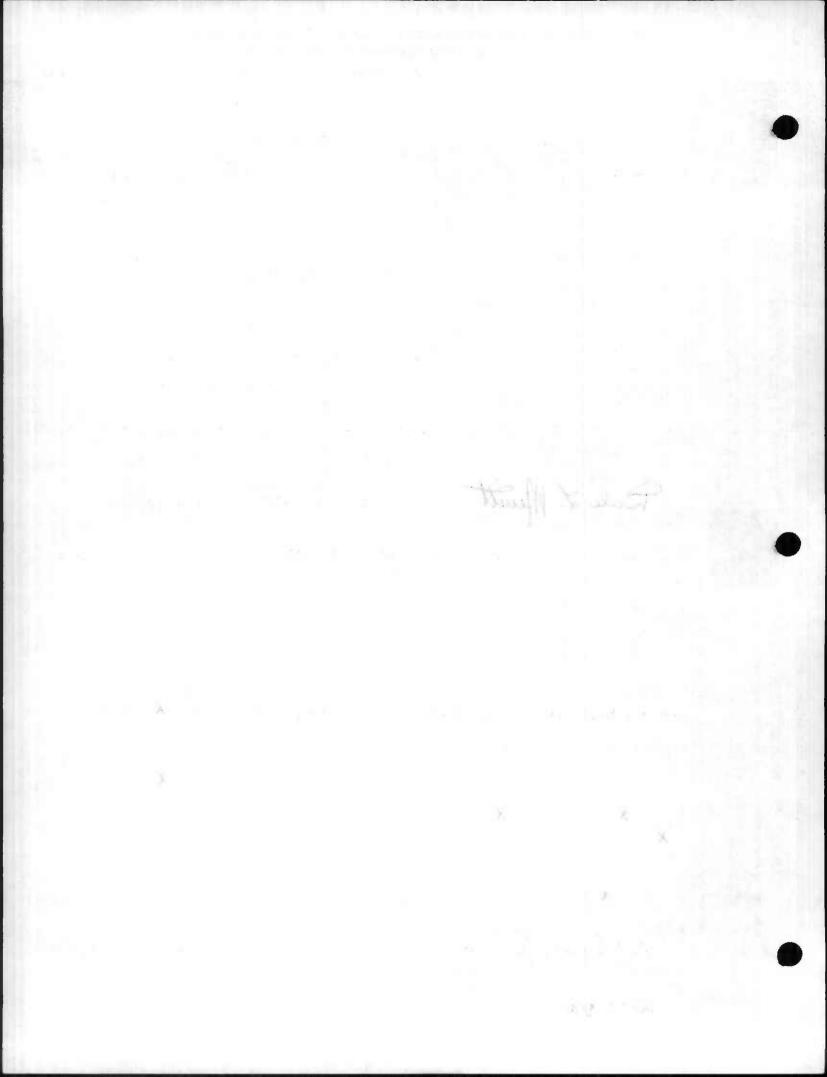
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Bond, Robert

DI		1. Decedent's Neme (First, Middla, L	ast)		Cert			2. Date of De		Ve	3. Time of Death	
Physicia /Medic		BARBARA ANN B	RANNON					JANUARY	7 10 19	Yeer 98	18:45 PM	
Examine		4a. Fecility Nama (If not institution, g	ve straat and numb	ber)			4b. City, Town, or	Location of Death	4c. County	of Death		
		MEMORIAL HOSPIT					CUMBERLAN		ALLEG	SANY		
Funerai Director		5. Sociel Security Number 6. 213-24-6510 Usual Residance of Decedent	Sex 7	. Age (In yrs. le		If Under 1 Yaa Months Days			th ly. Year) + 1926	9. Birthp Coun MARY	laca (Stata or Foraign try) LAND	
show		10e. State 10b. County		10c. City,	Town or Loca	tion				1	0d. Inside City Limits	
28a-f sho	ţò	MARYLAND ALLEGAN	Y	CUM	BERLANI)					XXYes 2 ☐ No	
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizan of 1	What Coun	try?	
23e	alc	824 SHAWNEE AVE.				2	1502		U.S	.A.		
urs e	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Wes Deced Armed Forc 1 Yas 2 If Yas, Give Yaar or Date	es? LXNo		as Decedent of as, specify Cu	Hispanic Origin? (S ban, Mexicen, Puer Specify:	Specify Yas or No nto Ricen, etc.)		e - Americ ck, White, WHI	etc.	
dical Ext	etec	15. Decedent's E (Spacify only highest g	ducation ada completed)		(Give kir	nt's Usuel Occu	a during most of wo	orking	16b. Kind of B	usiness/Ind	dustry	
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marked other t		17. Fathar's Nema (First, Middle, Las	t)		SINGER	SEWING	MACHINE 18. Mother's Na	CO . me (First, Middle,	SALES Maiden Suman	ne)		
o pey	o Be	ROBERT C. MILLE						ESTELLE S		/		
mati	P	19e. Informant's Name/Relationship			19b. Mailing	Address (Stree	et and Number or R			State, Zio	Code)	
Important: If Item 27 Is marked othe any injury or other treumatic event, once.		RUSSELI, F. BRANN 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 I 4 □ Donetlon 5 □ Other (Spec	☐Removal from St	ata ce	ace of Disposit metery, crema	ion (Name of tory or other pl	MET DRIVE	Data	20c. Location -	City or To		
Important: any injury		21. Signature of Funeral Service Lice	Went	+	MEF		ress of Fecility DAMS FUNE UR STREET			YLANI)	
physicia s the bur	by Physician/Medical Examiner	Immadiate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted evants resulting in deeth) Last	b	Due to (or	ENAL AI es e conseque as a conseque as a conseque	ence of):	CINOMA			1	4 years	
the at	ysic	Part II. Other significant conditions	contributing to deat	th but not resul	ting In tha und	erlying ceuse g	iven in Pert I.	23b. Did	tobacco uae co	ntribute to	the cause of deeth?	
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s been sign 2 should be	Completed by	Rt. rib, Adrenal	gland.						en eutopsy rmed?	ave	ere eutopsy findings bilable prior to mpletion of cause deeth?	
ate hes	E							10	Yas 2 No	10	Yes 2□ No	
ctor	Be	25. Wes cese referred to medical exeminer?					26. Plece of De	ath (Check only o	one)			
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= 10	Certification:	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Sulcide 6 Could not	on land	Day Year)	28b, Time of Injury		Yes 2□No		be how injury occurred			
I Direction by	ertil	4 ☐ Homicide determined	28e. Place of building	ne, rarm, stree	t, factory, office	pry, office 28f. Location (Street and Number or Rural Routa Number, City or Town, State)						
ne Funer	edicai	29a. Certifier (Check only one) 1 Certifying Plants 2 Medical Example 1	nysician: To the besi miner: On the besi and menne	is of exemination	ledge, deeth o	ccurred at the stigation, in my	time, date end plece opinion, deeth occi	e, end due to the urred et the time,	ceuse(s) end me date and plece,	enner as st end due to	eted. the ceuse(s)	
To t	Σ	29b. Signature and title of certifiar	1				nsa numbar		29d. Dete signe	d (Month,	Day, Year)	
?		18/18me	, 4. x	ND		D 1	4865		JAN.	u,	1998	
State Registra	e	DR R BARRERA M 31. Date find Worth Pay Year	EMORIAL H	OSPITA	L CUM		D MARYLAN	ID 21502				

BARBARA A. BRANNON



State of Maryland / Department of Health and Mental Hygiene 8 0 | 5 | 6

					Cer	rtificate c	of Deatl	7		Reg. No.	0 1	010
Physici /Medic		Decedent's Neme (First, Middle, Le WILBUR	STANLE	EY CLA	BAUG	GH			2. Date of De Month Januar	peth Dey	Yeer 198	3. Time of Death 5:20 pm
Examir		4e. Facility Neme (If not institution, git Solomons Nursine					4b. City, 1 Solo		ocation of Deet		of Deeth	
Funeral Director			Sex 1 M M 2 □ F	Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months De		or 24 Hrs. Min.	8. Dete of Bir (Month, De Nov 4,	th ey, Year) 1910	9. Birthp Cour Okl	piece (Stete or Foreign ntry) ahoma
h the Meryland r 28a-f show	tor	10a. Stete 10b. County Maryland Calve	ert	10c. City, To	own or Lo		ort Re	publ.	ic		1	10d. Inside City Limits 1 ☐ Yes 2 X No
23a or 28	ai Dire	10e. Street end Number 2602 Aster Roa	ad			10f. Zip Cod	0676			10g. Citizen of V		ntry?
items items	by Funeral Director	11. Maritel Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	es? ⊠ No	1	Wes Decedent of Yes, specify C	uban, Mexica	an, Puerto	pecify Yes or No Rican, etc.)		ck, White,	
	Completed	15. Decadent's E (Specify only highest gr. Elementery/Secondary (0-12)	ducation ade completed) College (1-4	or 5+)	(Give I	lent's Usuel Oc kind of work do DO NOT use rel	cupetion ne during mo irad)	st of work	sing	16b. Kind of Bu		
permit. Peges I end 2 should be filed within Department of Health and Mental Hygiene. Important: If term 27 is merked other than eny injury or other treumatic event, the Monose.	To Be Co	17. Fether's Neme (First, Middle, Last Lewis Edward Cla)		chemist federal govern 18. Mother's Neme (First, Middle, Maiden Surneme) Minnie Pauline Daniel							
end 2 sh talth and 127 is m		Mrs. Virginia S.								er, City or Town, ick, MD		
emit. Peges 1 er		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	(y)	ale	st Ch	sition (Name of netory or other p nurch Co	emeter		Dete 1/12/98	20c. Location -		
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Physician /Medical Examiner	ner	23a. Pent1. Enter the disease, or com shock, or heart feiture. List only Immediate Ceuse (Finel disease or condition resulting in death)	plications that cau		yous	OF						Approximete Intervel Between Onset end Deeth
eath certificete be executed attending physicien end I for use as the burial-trensit	in/Medicai Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In death) Last	b	Due to (or es								
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een sign	Completed by	CANONIE OSSIRUEITE POLASKIT							24e. Wes	en eutopsy ormed?	ev	ere eutopsy findings eileble prior to impletion of cause deeth?
ilcian: The law requiras ti certificate has been signe rector, paga 2 should be c	Be Com	25. Wes case referred to medical					28. Piac	a of Deel	1 Check only		1[Yes 2□No
	To	examiner?	Hospitel: 1 Inpe	atient 2 FR/	Outpetient	t 3□ DOA	Other:	ursing He	me 5∏Resi	dence 8 🗆 Oth	er (Specif	64)
ge He		27. Menner of Deeth 1 Maturel 5 Pending 2 Accident Investigation	28a. Dete of I (Month,		o. Time of Injury	28c. Ir	ijury et Vork?		ome 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how Injury occurred			
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To with	Σ	29b. Signeture end tille of certifier	Heigh	of my			anse number	58		JAN-		
		30. Neme and address of person who have a second of the se	WIC	of deeth (Item 23)	3-	Print) PR(ncf	F	REDE	RICK	1	1998
Star Registra		JAN 13		This Start	bor R	ardalle.						

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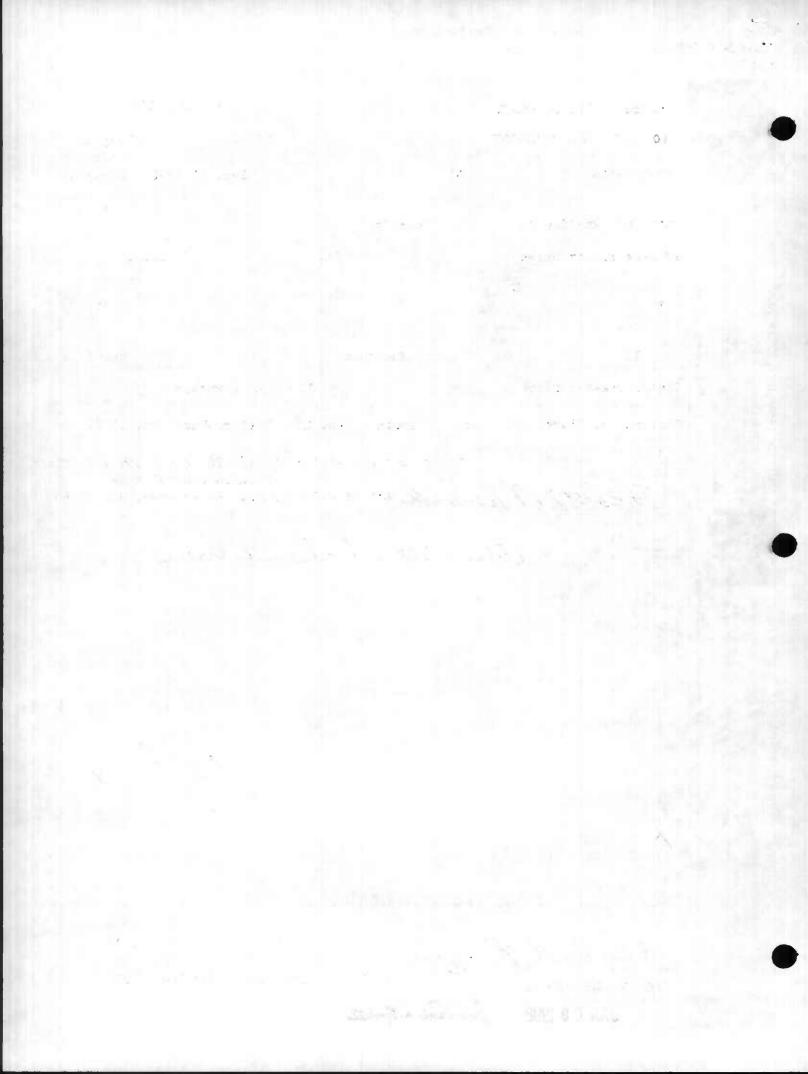
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CLARK	SR.	A December 1 August (Free M						of Death		2. Date of	Reg. No.	0 U	15	me of Death	
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Fune Direc		212-24-3544	1 ₹ M			Yrs.		ays Hours	Min.	8. Date of (Month,				tate or Foreign	
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nylan	9	10a. Stata 10b. Cou	nty		10c. City,	Town or Loca	ation							de City Limits	
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	Fune	11. Marital Status 1 Naver Married 2 N	Married 1	Armed Forces? If			as Decedent Yes, specify (☐ Yes 2 🛣	of Hispanic Ori Cuban, Mexicar No Specify:	n, Puerto I	city Yes or Rican, atc.)		Black, Whit	Amarican Indian, White, atc.		
nours iral'.	dby	3 Widowed 4 □ Divor	ced	Year or Datas:						3/		Vhite			
21215-0020 d within 72 hours afgiene.	Completed	15. Dece (Specify only hig	dent's Education Thest grade con	cation 16a. Decedent's Usu (Give kind of wo life. DO NOT u				ccupation one during mos	t of worki	ng	16b. Kind	of Business	Industry		
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Hygin H	S O	1 1 17. Father's Name (First, Midd	fle, Last)	0		Mec	hanic	18. Mothe	er's Name	(First, Mide	dle, Maiden Su				
arylan should be nd Mental	To Be	Victor Presto	n Clark	c				Marv	May	Hawh	aker				
Maryland 1d 2 should be file Ith end Mental Hy 27 is marked oth		Victor Preston Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Table 19b. Mailing Address)											Zip Code)		
1 and 2 Health e		Clarence H. C	lark, J	Jr S	Son	Rout	e 1 B	x. 245	War	fords	burg. H	Pa. 17	267		
of Herri		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramatic			20b. Plac	ce of Disposi	tion (Name of	of		Date		tion - City or		ate	
Pages Pages ment of ant: If It	,	4 Donation 5 Other		IVALITOITI STATE		Lawn	Memor	ial Par	k 1	/9/98	Hager	stown	Mar	vland	
Baltimore, pemit. Pages 1 ar Department of Hea Important: If item 2	once.	21. Signature of Funeral Serv	ice Licensee	201	_			ddress of Facili			Funeral		111		
m 80 E	9	Scot	TYY,	Yhu	mu	4	15 E.	Wilson	Blvd	. Ha	gerstow	vn, Md	217	40	
		23a. Part1. Enter the diseasa shock, or heart failure.	, or complication	ons that causa	d tha death.	Do not enter	the mode of	dying, such as	cardiac o	r raspirator	y arrast,			ximate al Between	
Physic				01		1 -		0			•			and Death	
/Medi Examir		Immediate Cause (Final disease or condition resulting in death)	a	(lite	worl	epolic		rdier	scul	n De	reare				
		resulting in death)		7 11	Due to (or a	s a consequ	ence of):								
b is	edical Examiner		b												
execu	Exal	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			Due to (or a	s a consequ	ence of):								
BOX 68760, eath certificate be executed ettending physician end	Ca la	Cause (Disease or injury that initiated events	c		Due to /or a	6 9 0000000	ance of):								
68 ifficat g phy	m —														
The Cords, P.O. BOX (The lew requires that the death certif the has been signed by the ettending	Physician/M	d													
deatt		Part II. Other algnificant cond	litlons contribu	iting to death	but not resulti	ng In the und	leriying cause	e givan In Part I	l.	23b. D	ld tobacco us	sa contribute	to the ca	use of death?	
at the de	hy:									1	☐ Yes 2☐	No 3□P	robably	4 Unknown	
S, P.O.	b y													^	
Records, he lew requires to a has been signed by the control of th	Completed									24a. W	as an autopsy rformed?	0	available	opsy findings prior to	
HeC.	4 0									l	inted		of death?	n of ceuse	
The The	Con									1,1	Ves 2□	No	1 Yes	2□ No	
Of Vital Physician The	Be B	25. Was cese referred to med examiner?		14-1					e of Death	(Check on	ly one)				
Physic chils of this o	5	1XXYes 2 □ No	Hospi	1 L Inpat		R/Outpatient	3□ DOA				esidence 6 [cify)		
Oivision of Vital or Attending Physician: T after death. Director: After this certifice	lon	27. Manner of Death 1 DNatural 5 ☐ Per		Ba. Date of Inj (Month, Da	ay Year)	8b. Time of Injury	28c.	Injury at Work?		28a. Descri	be how injury of	occurred			
VISION Attending or death.	Cat	3 Suicide 6 Cou	estigation	8e. Place of In	iun - At hom	e farm stree			☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number)					Number	
Div A affer Direct Dire	Certification:	4 ☐ Homicide det	ermined		tc. (Specify)	0, 14,111, 01101	st, ractory, on			City or	Town, State)				
DIVISION Of VITAI Report to the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he comployed tilled in the the funeral director.	edical C	(Check only 20 Medic	al Examinar:	On the basis of	of examination			ne time, date an my opinion, dea						usa(s)	
thing	Med	29b. Signatura and title of cert		and manner s	tated.		29c 1 k	cense number			29d Date	signed (Mon	h. Day V.	ear)	
- × - × - 8	3		,0	11.			250. 28	O.C.M.	E.			07, 19			
		1 Reads	re Me	12	10/	0									
		30. Name and address of pers						et, Bal	timo	ce. Ma	rvland	21201	11.		
		THEUNORE	Moten							-,	1				

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 9 1938

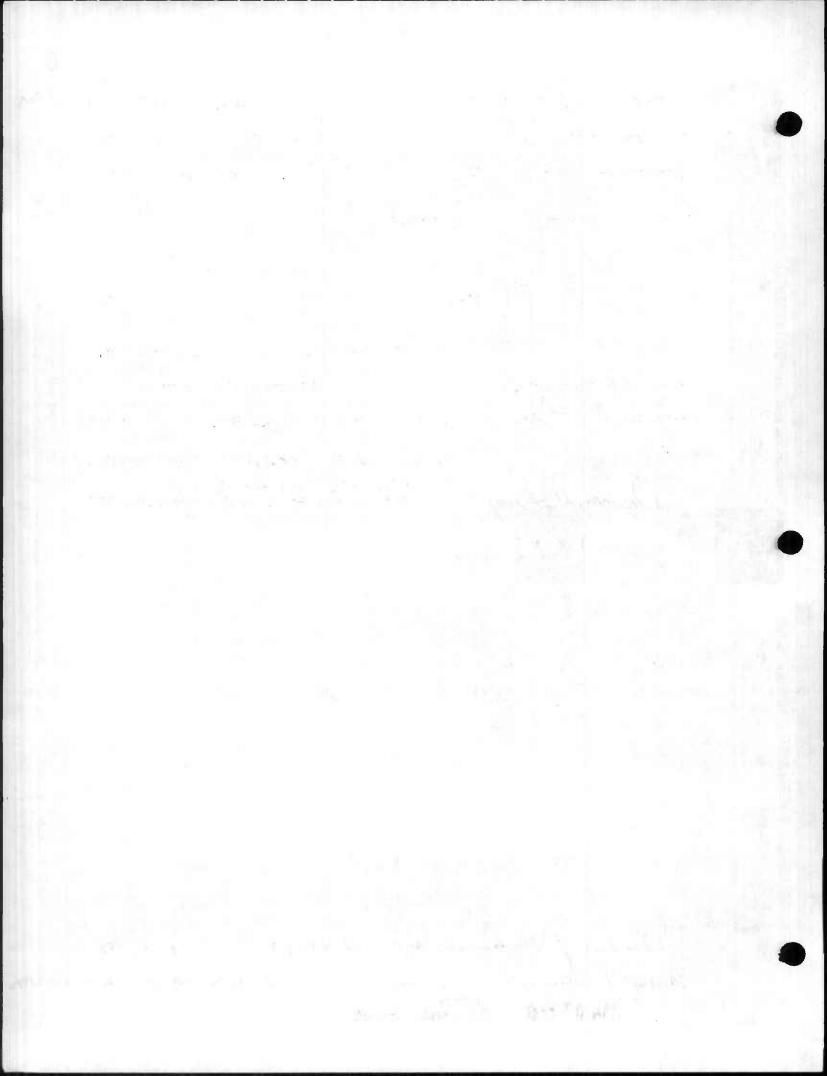


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** January 4,1998 Year 6:40 PN CHARLES WISSIAM CROSS /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 329 Emmert Road Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Yeer) Mar. 31,1945 Birthplaca (Stete or Foreign Country) **Funeral** 1 M 2□ F 217-42-9406 Yrs Director 52 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Wedical Examiner must be notified at Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Emmert Road 21740 U.S.A. Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1™ Yes 2 □ No If Yes, Give Year or Dates: 1963to66 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "nature." 1 Nevar Married 20 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Ladel Truck Driver Aluminum Mfg. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Clyde Edwin Cross, Sr. Kathryn Elmira Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Nancy Lee Cross / Wife 329 Emmert Road Hagerstown, Maryland Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Jan. 8,1998 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Douglas A. Fiery Funeral Home reusto 1331 Fastern Blvd. N. Hagerstown, Md. 23a Part 1 Enter the usease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shows, or heart salure. List only one cause on each line. Approximate Interval Between Onset and Death Physiclan /Medical Immediata Cause (Final Rend Cell Carcinon disease or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last use as the bunal-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown g Completed 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4□ Nursing Homa 5 ☐ Residence 6 □ Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1. Melanneh MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCormack Medocal Campus Rd. Site 130 baserstown, no 21742 11110 31. Date filad (Month, Day, Year) 32. Registra JAN 97 Registrar

DHMH 16 Rev 6/95



		4.0	Type or Print State of Ma	ryland / D		ent of H	lealth and	Mental Hy	giene Reg. No.	01519
Physici	an	1. Decedent's Name (First, Middle, Last JOHN WALTER C	HENEY SR.					2. Date of Dec Month		3. Time of Death
/Medic	al	4e. Facility Name (If not institution, give					th City Town or	JANUARY Location of Deeth		
Examin	er	MEMORIAL HOSPITAL	street end number)							
uneral		5. Social Security Number 6. S	ex 7. Age	(In yrs. lest birt		der 1 Year	UMBERLAN If Under 24 Hrs	8. Date of Birt	h	GANY 9. Birthplace (State or Fore
irector		220-03-7076	M 2□ F	79	rs. Mont	hs Days	Hours Min	. (Month, De		MARYLAND
3		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Lim
fsho	70									1 ☐ Yes 2 ☐
iens. The Medical Exercites that be notified at	Director	MARYLAND ALLEGA 10e. Street and Number	NY.	CUMBE		Zip Code			10g. Citizen of W	
23a o		12806 IOKA DRIVE	N.E.			215	502		U.S.A.	
ME IN	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver In U,S.	13. Was De	ecedent of Hi		Specify Yes or No-	14. Race	- American Indian, White, etc.
or It	Y Fu	1 Never Married 2 Married	1√ Yes 2 No			s 2 No	Specify:	to moan, etc.)	Specify:	
ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	W11						WHITE
edic.	Completed	15. Decedent's Ed (Specify only highest gre	de completed)		Decedent's U (Give kind of life. DO NO	Jsual Occupa work done o T use retired	ation during most of wo f)	rking	16b. Kind of Bus	siness/Industry
than	E	Elementery/Secondary (0-12)	College (1-4or 5+					EY LUMBE	R CO.	LUMBER
and montal raylents. Is marked other than aumetic event, the Ma	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Malden Sumame)
arkad o	2	HAROLD K. CHENEY	Z				NELLIE	PEARL WA	LTERS	
7 is marka traumatic		19a. Informant's Name/Relationship (7						ural Route Numbe		
item 27 other tr		RENA A. CHENEY	WII				VE N.E.	CUMBERL		
3 = 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐			, cremetory	or other plec		Date		City or Town, State
Important: If any injury or once.	-	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		SUNSET			JAN 7	1998	CUMBERLA	ND MARYLAND
lmpo any ir		21. Signate of Purchal Service Coeff	M +	5		and Addres		ERAL HOM	E	
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	lications that ceused the	he death. Do n	404	DECATU	IR STREE	CUMBER	LAND MAR	YLAND
/sician		shock, or heart failure. List only	one cause on eech line	•						Interval Between Onset and Death
ledical		Immediate Cause (Final disease or condition	CAR	Dine	A	RRE	FST			15 min
aminer		resulting in death)	aD	ue to (or es a c	onsequence	of):				
Sit	mlner		a CAR b. ACUTE	= my	OCR	HRDI	1A2 11	UFAR	CTCON	V 30 m/
sician and burial-trans	Exan	Sequentially list conditions, if any, leading to Immediate		ue to (or as e c						
sician buria		ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events	c	11.4	185-1-111					
as the l	2	resulting in death) Last	Di	ue to (or as a co	onsequence o	or):				
use	an/		d							
the atta	Physician/Medical	Part II. Other significent conditions co	ntributing to death but	not resulting In	the underlyin	g ceuse give	en in Part I.	23b. Did t	obacco use cont	tribute to the cauea of dea
igned by the a be datached								10	res 2000	3 ☐ Probably 4 ☐ Unkn
sign ld be	d by							24a Was	an autopsy	24b. Were eutopsy finding
peen s	Completed								med?	eveilable prior to completion of cause
ata has page 2	E O							101	(ac a No.	of death?
or.	0	25. Was cese referred to medicel					26 Place of De	eth (Check only o	6.	1 ☐ Yes 2 ☐ No
O D	0 0	examiner?	Hospital:	2 ER/Out	patient 3	DOA Othe	or	dome 5 ☐ Resid		r (Specify)
After th funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Ti	me of jury	28c. Injury Work	at k?	28d. Describe h	ow injury occurre	od
or: Al	catio	2 ☐ Accident Investigation			М		Yes 2 □ No			
Director: Af d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, fan (Specify)	m, street, fac	tory, office		28f. Location (S City or Tox	Street end Numbe m, Stete)	r or Rural Route Number,
To the Funeral D		29a. Certifier Certifying Phy	releion. To the best of	en a les en de de	death		- 4-4- 4 /			
Fun	edical	(Check only one) 29a. Certifier Certifying Phy Certifying P	sicien: To the best of inar: On the basis of eand manner state	xamination end	death occurr or Investiget	ed et the tim ion, in my op	e, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s) and man date end place, er	ner as stated. nd due to the cause(s)
			o diane							

State Registrar

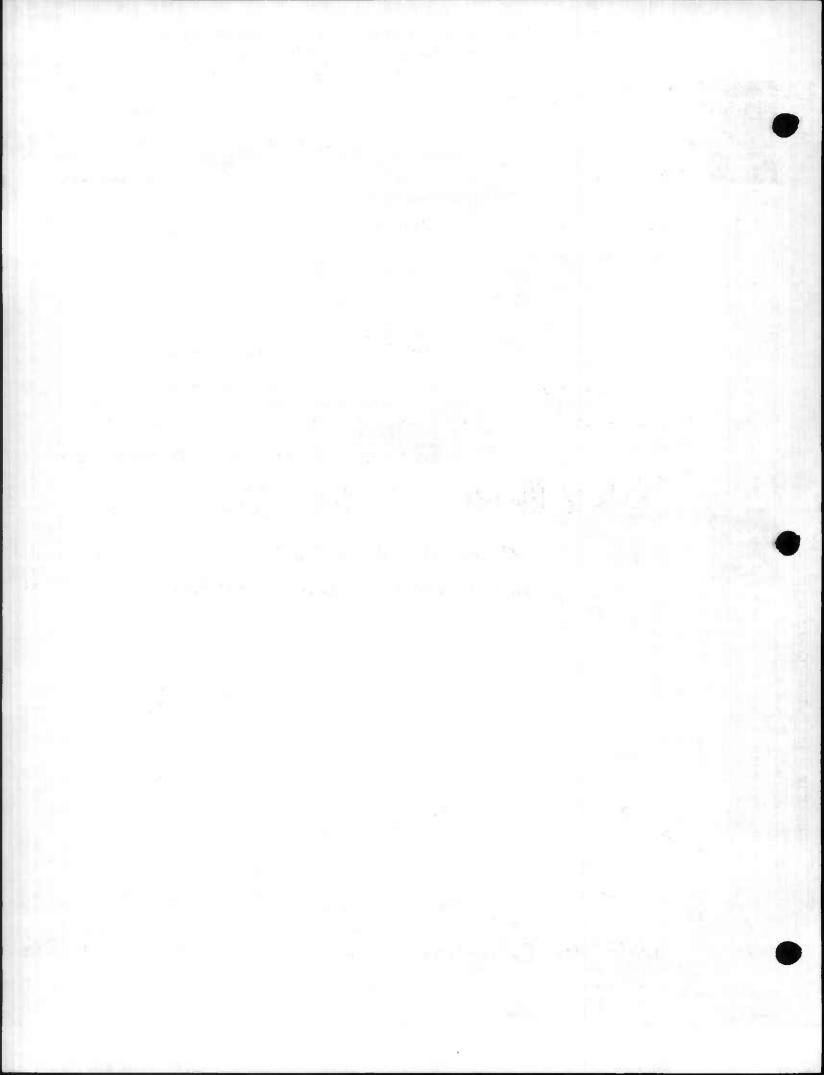
DR WILLIAM LAMM 31. Date filed (Month, Day, Year) JAN 0 6 1998

47 VIRGINIA AVE. CUMBERLAND MARYLAND

21502

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

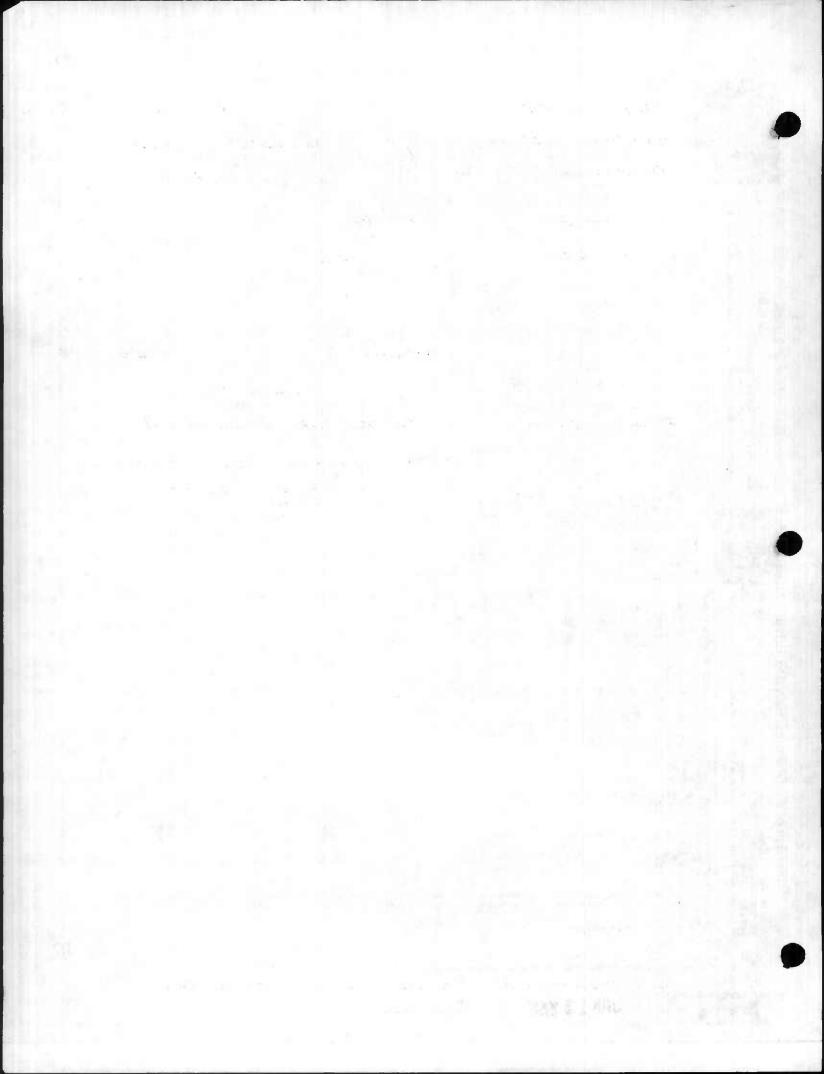
16



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Jan 11, Mary Louise Capel 5:00 a.m. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cumberland Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2 1 F Days 213-12-9146 Yrs. 76 Director Jun 10, MD Usual Residence of Decedent the Maryland 10a State ahow 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Expresser must be notified at Director Allegany Cumberland 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 19 N. Lee Street 21502 Funerai USA 12. Was Decadant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Raca - American Indian, Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hygiene.
Ant: If item 27 is marked other than "natural", or itea way or other traumatic event, the Medical Expension uny or other traumatic event, the Medical Expension. Black. Whita, atc. 1 ☐ Never Marriad 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Twigg 2 Edith Brinkman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trait Walter E. Capel-son 9928 Moxley Road; Damascus, MD 20872 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 01/14 Frostburg, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 23a. Part1/Enter the disease, or complications that carried the de shock, or heart failure. List only one cause on each line. Cumberland, MD To not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final BACTERIAL PNEUMONIA ONE WEEK disease or condition resulting in death) Examiner Due to (or as a consequenca of): Physician/Medical Examiner the burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest pue Dua to (or as a consequenca of): Division of Vital Records, P.O. Box 68760. the attending physiclan The law requires that the death certificate be Due to (or as a consequence of): for Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? signed by 1√ Yes 2 No 3 Probably 4 Unknown EMPHYSEMA ò Completed 24a. Was en autopsy performad? 24b. Wara autopsy findings available prior to completion of causa of death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 (Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 15 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and pleca, and dua to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MI JANUARY 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Daniel Leibman, M.D.; Memorial Avenue, Cumberland, MD 21502 31. Date filed (Month, Des Year) State Registrar



Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

	10a. Stata	10b. County	10c.	City, Town or	Location				10d. I	nsida City Limi
Director	WV	Minera	al	Burlin	gton				•	I□Yas 2∭N
Dire	10e. Sfreet end Nu	ımbar			10f. Zip Cod	la		10g. Citizan of Wh	at Country?	
	Rt 1, Bo	ox 96 A			26	710		U.S.	A.	•
by Funeral	11. Marital Status 1 ☐ Never Man 3 🏋 Widowad	riad 2 Married	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yas 2 🗓 No If Yas, Giva	U,S. 13	3. Was Dacedant of If Yas, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puart No Spacify:	pacify Yes or No- o Rican, atc.)	14. Race - Black, Specify:	Amarican Ir Whita, atc.	
	3 (Al Andoward		Year or Datas:	1000					Whit	
Completed	Elementery/Sac	15. Decedant's Ed cify only highast gra ondary (0-12)		(Gi		cupation one during most of work tired)	king	16b. Kind of Bush		У
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To Be		L. Canar				Ica		Maidan Sumame) asker		
	19a. Informant's N	lame/Ralationship (7	Type, Print)	19b. Ma	illing Address (Str	eet and Numbar or Ru	ral Routa Numbe	r, City or Town, St	ate, Zip Coo	le)
	Vance De	ean Davy	Son	Rt	1, Box 9	6 A Burl	ington,	WV 2671	0	
		sposition Cramation 3 Othar (Specify	namoval irom Stata		position (Nama of rematory or other emetery	placa) Jan 6, 19	Data	20c. Location - Ci		
		undral Sarvice Lioun			22. Nama end Ad			- uz z z z z g c	on,	. =07.10
	14	VV	1 1			Smith Funer				
	23a Part Intel	loug le	pications that caused the de			Main Stree			26726	an describe
ı	La Lincoln		olications that causad tha de ona causa on aach lina.	adii. Do not e	amar ma mode or	dying, such as cardiac	or raspiratory en	asi,	Inte	oroximata erva! Batween sef end Daath
	Immediata Causa disaasa or condition	on	a Sepsis an	d Res	piratory	Failure			On	e Week
	resulting in death)			(or as a cons						
ine			Pneumonia						On	e Week
i Examiner	Sequentially list co if any, leading to in cause. Enter Under Causa (Disease or	onditions, mmadiata arlying		(or as a cons					Fi	ve Year
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an/Med	rasaning in about	•	d							
/sician/Med		ficant conditions co	dontributing to death but not re	asulting in tha	undarlying causa	givan in Part I.	23b. Dld to	obacco uae contri	ibute to the	cause of deat
by Physician/Medical	Part II. Other algnit		ontributing to death but not re					. /		cause of deat
by Physician/M	Part II. Other algnit					nic Renal		an autopsy	Probably 24b. Wara a	utopsy findings
by Physician/M	Part II. Other algnit				ng, Chro	nic Renal	1 🗆 Y 24a. Was a perfor	an autopsy med?	24b. Wara a availab compla of daati	4 Unknount open untopsy findings ia prior fo tion of cause
e Completed by Physician/M	Part II. Other algnit	ysplasia (ng, Chro	nic Renal	1 U Y	an autopsy med?	24b. Wara a availab compla of daati	utopsy findingsia prior to
o Be Completed by Physician/M	Part II. Other algorit AngioDy 25. Was casa rafar axaminar?	ysplasia (of Cecum, GI	Bleedi	ng, Chro Fail	nic Renal ure 26. Placa of Dea	1 Y 24a. Was a perior 1 Y 4th (Check only or	an autopsy med?	24b. Wara a availab compla of daatl	utopsy findings ia prior fo tion of cause
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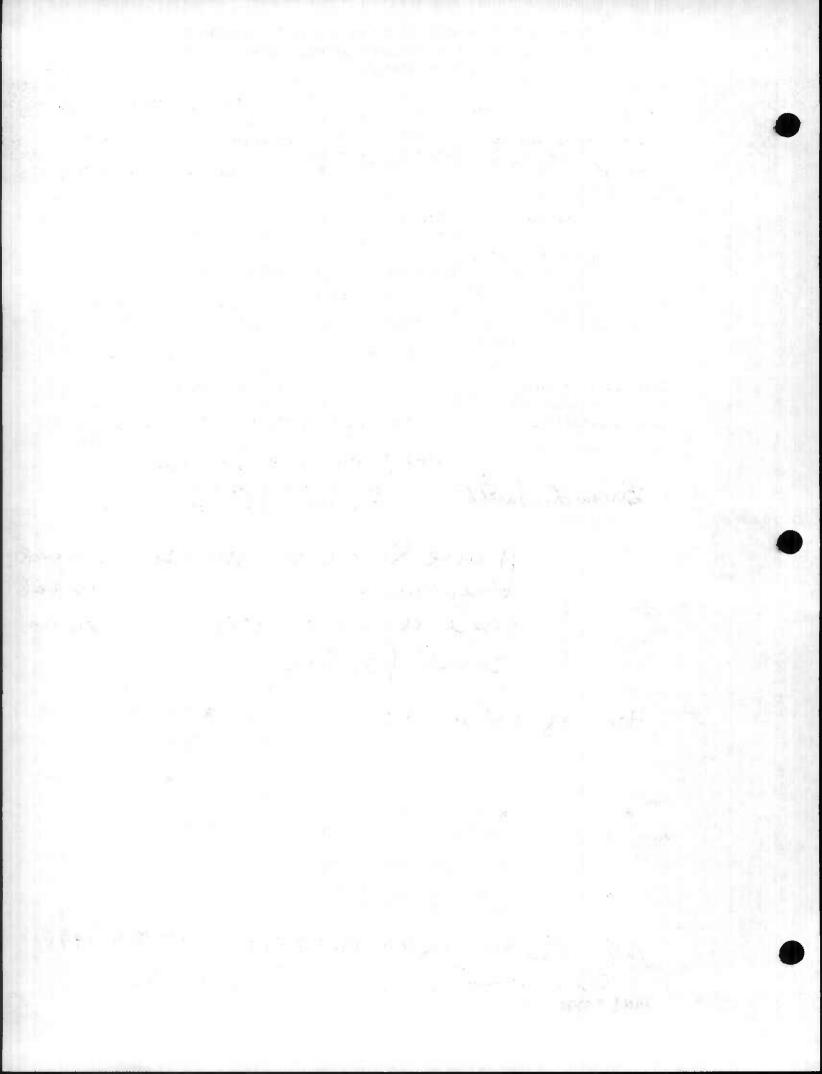
Registrar

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State of Maryland / Department of Health and Mental Hygiene 98 0 1522

				C	Certificate of	of Death	R	eg. No.	01066
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/Medi		Mary L.	Davis			Ab Oh, Tour			
Examir	ner	4a. Facility Nama (If not institution, gi					or Location of Deeth	4c. County of	
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Funeral Director			Sax 7. Aga	(In yrs. last birtho	Months Da		in. B. Data of Birth (Month, Day, Feb. 15	Year) 5,1911). Birthplaca <i>(Stata or Fore</i> <i>Country)</i> West Virgini
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d d d	ō	MD Alle	gany	Rawli	nge				1 ☐ Yas 2 ☐
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within 72 hours biller beath with the maryland ene. Than "neturel", or liems 23s or 28s-f show the Medical Examiner must be notified at	rai Dir	23903 McMullen			2	1557		USA	
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iene. than "natural", or itema 23a or 28a-f ahow tha Medical Examinet must be notified at ompleted by Funeral Director		1 ☐ Navar Marriad 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yas 2 📉 No If Yes, Give Yaar or Datas:		1 □ Yas 2 🔯 1	No Specify:		Specify:	White
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Men	2	Lawrence G. Bea	aver			Ida	M. Norther	raft	
		19a. Informent's Name/Ralationship	(Type, Print)	19b. N	Nailing Address (Str	aat and Numbar or	Rural Routa Number	City or Town, St	ata, Zip Coda)
₹2°		James L. Davis/	Son	2	3901 McM	ıllen Hig	hway, S.W.	Rawlin	ngs, MD 215
0		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Space)			isposition (Nama or cramatory or other c Memoria		Jan.11	20c. Location - Ci	
Depertment Important: any injury once.		21. Signature of Funaral Sarvice Lice		1 O COMA	22. Nama and Ad		s 1998	Keyser,	WV
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ourie		Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury	Sehe	12 ((movice	(0	PO		71074
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within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	edicai	29a. Cartifier (Check only one) Cartifying Pi 2 Madical Example	hysician: To the best of miner: On the basis of e	xamination and/o	r Investigation, in m	y opinion, daath oo	curred at tha tima, de	ata and place, and	d dua to tha causa(s)
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Physician Jan 7, 1998 Ethelinda DeLawder 6:15 pm /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Devlin Manor Nursing Home Allegany Cumberland 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2KDF Hours Min Yrs Director 217-10-4421 84 MD Feb 6, Usual Residence of Decedent death with the Maryland 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1√2 Yes 2 □ No Allegany Cumberland 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 235 Paca Street 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Detes; 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. pernit. Pagas 1 and 2 should be filed within 72 hours aftar o Department of Haalth and Mental Hyglena. Important: if Item 27 Is merked other than "natural, or the any Injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify 3 ₩idowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Austin Fortney Ollie (McKenzie) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sharon Winner-daughter 11 Holly Avenue LaVale MD 21502 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 01/10 Westernport MD 22. Name end Address of Fecility
Scarpelli Funeral Home, P.A. 21. Signeture of Funeral Service Licensee Cumberland MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** carcinoma to Lungs Immediate Cause (Final disease or condition resulting in deeth) /Medical 1 Years Examiner Examiner siclan and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) P.O. Box 68760, attanding physiclan for usa as the buris Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be datached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nema Records, þ Completed 24e. Wes en autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? paga 2 200 No cartificate 1 ☐ Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. S Funeral Director: After this cartificately filled in by the funeral director. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2□No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) á 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. Medical 29a. Certifier to the Fune (Check only one) To the 29b. Signature end little 29c. License number 29d. Date signed (Month, Day, Year) 9

Jan 9

1998

D 33280

625 Kent Avenue Cumberland MD 21502

Marker Reskill

pour

32. Registrar's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. Sunil Gupta

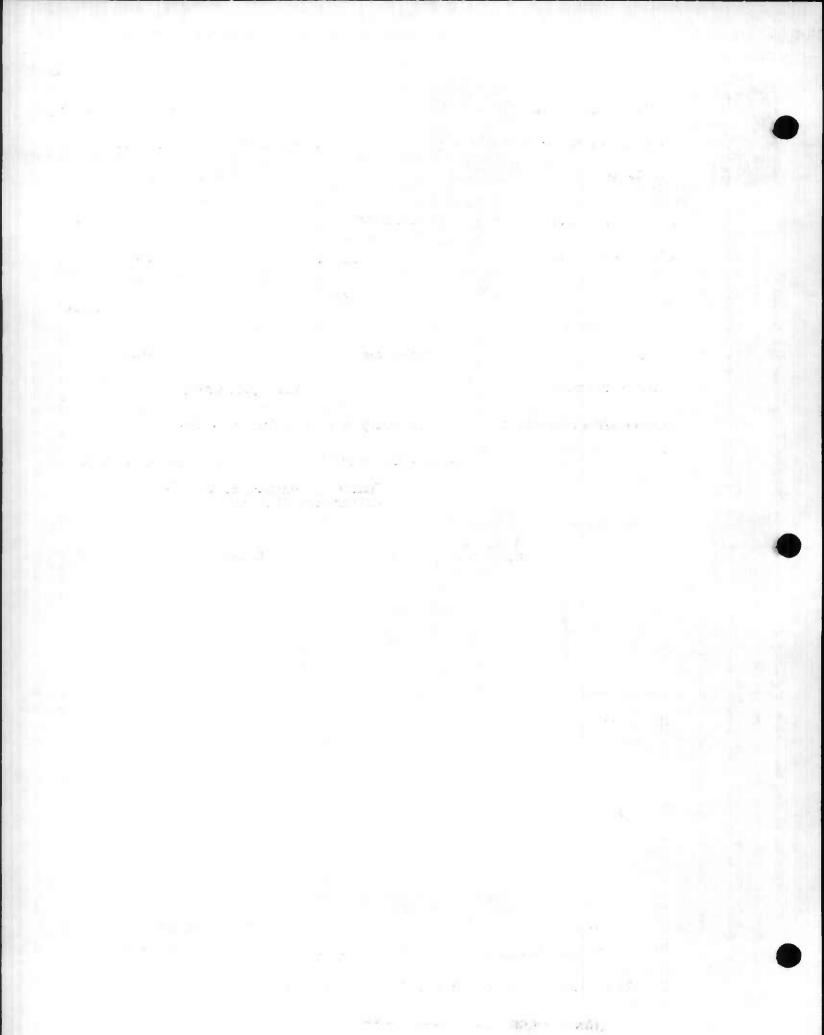
31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

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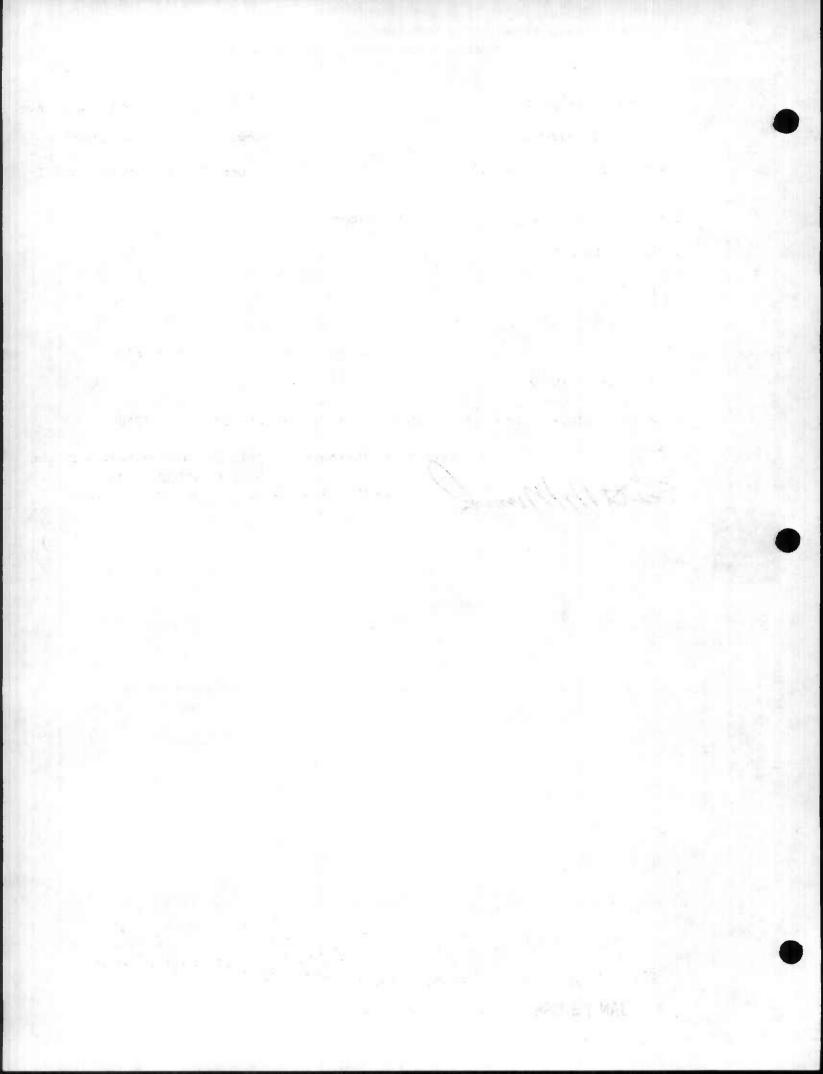
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Registrar



State of Maryland / Department of Health and Mental Hygiene

		. Decedent's Nama (First, Middla, Las	1)		Certifi			2. Date of D			3. Time of Death
rysician Medical		Phyllis Derr EV	ES					Month Janua	ery 12,	Yaar 1998	8:31 a.m
wedica: kaminer		a. Facility Name (If not Institution, give		r)			4b. City, Town, or				0.51 4.11
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To Be Completed by Funeral Director		Maryland Washing	ton		Наов	stown					1 ☐ Yas Ž☐ No
Director	1	0e. Street and Number				f. Zip Code			10g. Citizen of V	Vhat Coun	try?
a D		11828 Linbar Driv	e				21740			USA	
by Funeral		1. Marital Status 1 ☐ Naver Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedan Armed Forcas 1 Yes 2 If Yes, Give Year or Datas	7 No		ecedent of specify Cul	Hispanic Origin? (pan, Maxican, Pue Specify:	Specify Yes or Norto Rican, atc.)	o- 14. Race Blace Specify	e - Americ k, White,	
eted		15. Decedent's Edi (Specify only highest grad	cation	1	6a. Decedent's	Usual Occu	pation during most of we	orkina	16b. Kind of Bu	siness/inc	lustry
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ပိ		12 7. Fathar's Name (First, Middle, Last)	0]	ecept	ionist	(ett 4.41.c.a)	physic		
B		Charles Amos Kibl	or						, Meiden Sumem	a)	
2		9a. Informant's Name/Relationship (T			IOh Malline Ad	danas (Chas	-	a Derr		0 7.	
		Charles A. Kibler			_		tend Number or F Dr., Hag				Code)
	2	Oa. Method of Disposition	DIOCH		of Disposition			Date	20c. Location -		wn State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		3	etery, cremetory Haven						
	2	Signature of Funeral Service Licens		Ne d				1-15-98			Maryland
once.		K. XIA	20	//			lson Blv		FUNERAL		
	-	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	Intions that cause	o the death. I						rid.	Approximate
Physician/Medical Examiner	Sil	mmediate Causa (Final isease or condition esulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying leuse (Disease or injury nat initieted events sesulting in death) Last	Car	Due to (or as Due to (or as	a consequence a consequence a consequence a consequence	of): of): of): of):	of Parl		egar.		Onset and Death
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sici	P	art II. Other significant conditions con	tributing to death t	out not resulting	g in the underly	ng cause gi	ven In Part I.	23b. Dld	tobacco use con	tribute to	the cause of death?
þ	-	Left O	ceipt	al h	llow	hag	r	10	Yes 2□ No	3 Prob	ably 4□Unknown
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	L							1 🗆	Yes 2 No	1□	Yas 20 No
Be	2	5. Was case referred to medical examiner?	lospital:			Ot		ath (Check only			
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tion		1 ☐Natural 5 ☐ Pending investigation	(Month, De	y Year)	Injury	28c. Inju Wo	rk? Yes 2 □ No	20d. Dascribe	now injury occurr	5 0	
Certification:		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of in building, e	jury - At home, ic. (Specify)				28f. Location (City or To	'Street end Numbe wn, Stete)	er or Rurai	Route Number,
edicai (2	Pa. Certifier 1 Certifying Physical Check only 2 Medical Examination	ician: To the best er: On the basis of and menner st	t examinetion :	ge, death occu and/or investige	red at the ti	me, date and place	e, and due to the urred et the time,	cause(s) and mar date and piace, a	nar as stand	ated. the ceuse(s)
Medical Certification: 1	29	b. Signature and title of certifier		Λ		29c. Licens	se number	3	29d. Date signed	(Mgnth, E	Day, Year)
		1 part		1 111	いり	D	41131		1/19	4/98	7
	30	. Name and eddress of person who co	mpleted cause of	leath (Item 23s	a) (Type Print)	Ter	LAY 1	· CORR	eces	Von.	0
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death January 3, 1998 5:20 p.m. GRANVILLE THEODORE EASTERDAY 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 21460 Greenbrier Road Boonsboro Washington If Under 24 Hrs. 8. Date of Birth Hours Min. July 9, 1903 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Deys 220-10-3992 Months 94 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Washington Boonsboro 1 ☐ Yes 2 XNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21460 Greenbrier Road 21713 USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Raca - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Laborer Cement Company 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Jacob Easterday Edna Reeder 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ruth Easterday, Wife 21460 Greenbrier Road, Boonsboro, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Boonsboro Cemetery Jan. 6 Boonsboro, Maryland 21. Signature of Funeral Septice Licensi 22. Name and Address of Facility Douglas A. Fiery Funeral Home RODI 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final Chely Scular Accident Due to (or es e consequence of): one runth diseese or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown UROPATHY 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical **Examiner**

and

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10e. State

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after nent of Health end Mantal Hygiena.

al Hygiena.

is marked o

other traumatic

Department of Health e Important: If item 27 is any injury or other tra

Baltimore, Maryland 21215-0020

Examiner Physician/Medical signed by t þ Completed paga 2 Be 2 Certification: Director: A

or Attending Physician: The law requires that the death certificate be axecuted

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After

within 24 hours a To the Funeral D completely filled

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Medical

death.

Division of Vital Records, P.O. Box 68760.

OBSTRUCTIVE

1 ☐ Yes

28d. Describe how Injury occurred

1 ☐ Yes 2 12 No

		2	Place of Deeth (C.	heck only one)	
☐ ER/Outpetient	3□ DOA				6 ☐Other (Specify)

D43590

Hospitel: 1 ☐ Inpatient 2 2 No 28e. Dete of Injury (Month, Dey Yeer) 27. Menne of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 PNaturel 1 ☐ Yes 2 ☐ No 2 Accident

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

2 1000

29e. Certifier (Check only one)

6 Could not be determined

REFO

25. Wes case referred to medical

1 Yes

3 Suicide

JOH0

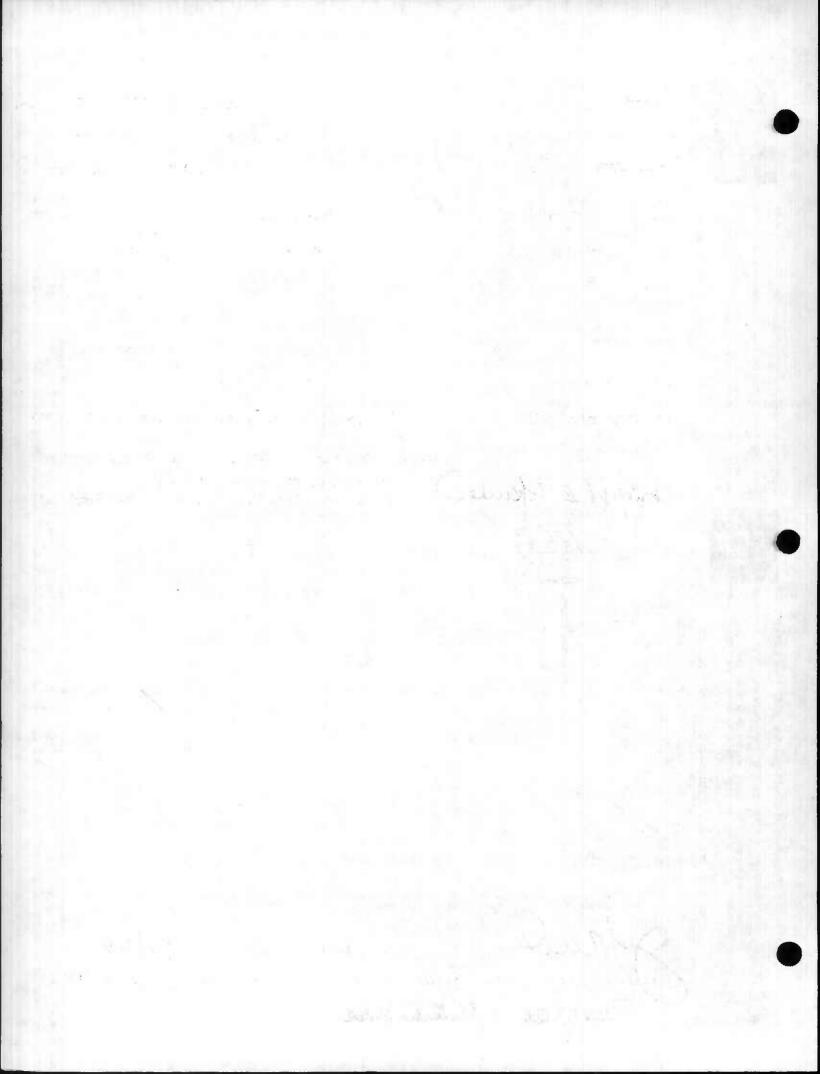
4 Homicide

12 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29c. License number 29d. Date signed (Month, Dey, Year)

of person who completed cause of deeth (Item 23e) (Type, Print)

BLUD SMITHS BUNG, MID 22911 JEFFERSON

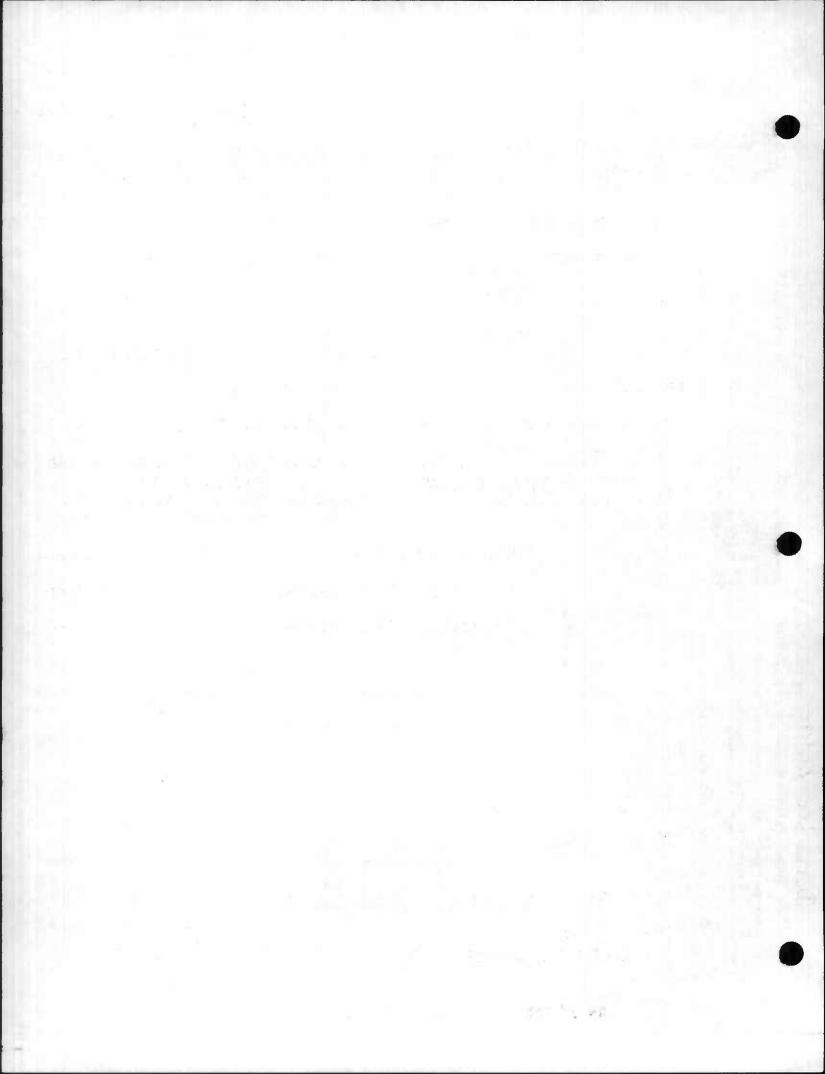
State Registrar 32. Registrar's Signature Julia Deviden



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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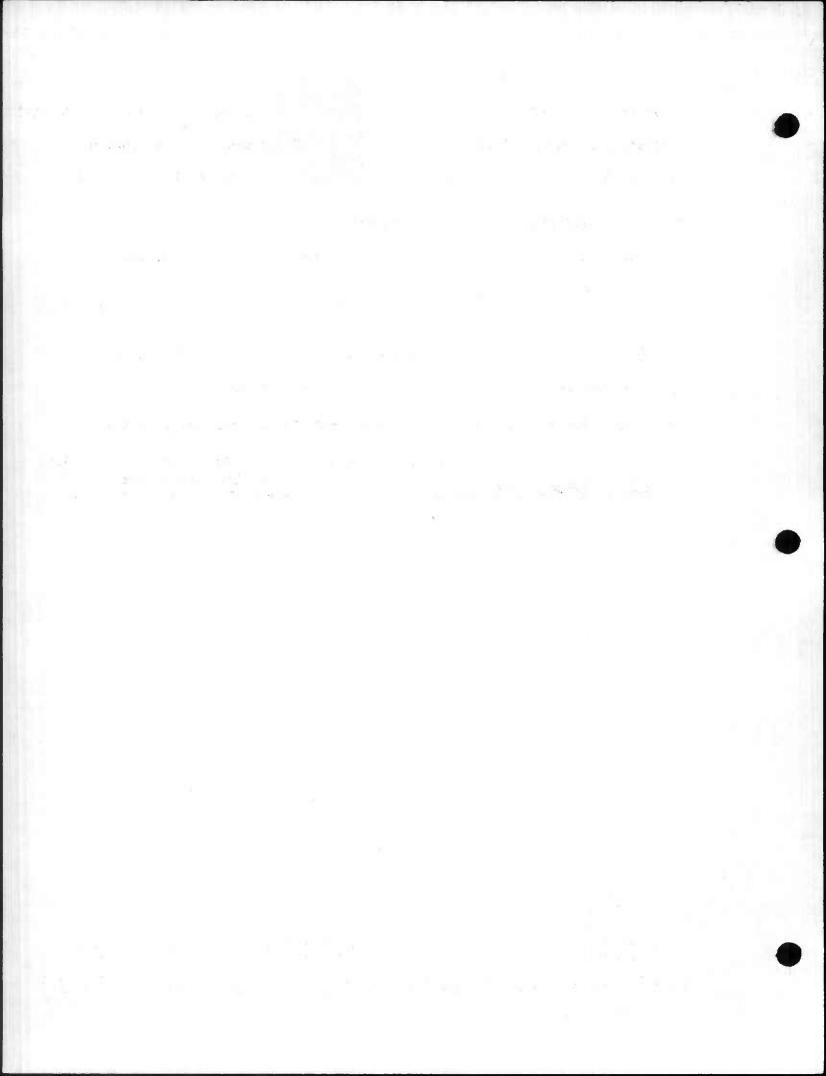
DHMH 16 Rev 6/95



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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death Month Yaar 6:15 Elzie Lionel FARROW 7 1998 January 4a. Facility Name (If not institution, give straat end number) 4b. City, Town, or Location of Daeth 4c. County of Daath 11332 Greenberry Road Washington Hagerstown If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 1 M 2 □ F Days Hours Yrs 220-16-3871 86 Nov 12 1911 Maryland Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Maryland | Washington Hagerstown 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 11332 Greenberry Road U.S.A. 21740 12. Wes Decadant Evar in U,S. Armed Forces? Was Decedant of Hispanic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2X No If Yas, Giva Yaar or Dates: 1 ☐ Navar Marriad 2 ☐ Married Specify: 3 ☐ Widowad 4 ☐ Divorced White 15. Dacedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 0 Dock Worker Freight Cargo 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surname) John Farrow Nan Shank 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) <u>Ida Lane Farrow - Wife</u> 11332 Greenberry Road Hagerstown, Md. 21740 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) St. Paul's Cemetery 1-10-98 Clear Spring, Maryland 22. Nama end Addrass of Facility Minnich Funeral Home 21. Signatura of Funaral Servica Licansas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximata Intervel Batween Onsat and Deeth Immediata Causa (Final disaase or condition resulting in deeth) Dua to (or as e consequance of): Sequantially list conditions, if any, leeding to immediata cause. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting In daeth) Last Dua to (or es e consaquence of) Dua to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Homa 5□ Rasidanca 6 □ Other (Specify) 28a. Data of Injury (Month, Day Yaar) 28c. Injury et Work? 28d. Describe how Injury occurred 5 Panding invastigation

Physician /Medical Examiner

physician and s the buriel-transit

attending p 98

signed by t

page 2 s hes

funeral director.

filled in by

Be

Certification: To

Medical

certificate

After this

24 hours efter death. Funeral Director: A

within 2

or Attending Physician:

Hospital

The lew requires that the death certificete be executed

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natt any Injury or other traumatic event, the Medica once.

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed by

25. Was casa rafarrad to medical axaminar? 1 Yes 2 Ne

27. Manner of Daath 1 Naturel 2 Accident 3 Suicida

29a, Cartifier

(Check only onel

6 Could not be daterminad 4 ☐ Homicida

28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata)

14 Cartifying Physician: To the best of my knowladge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner estated. 29b. Signatura end titla of certifiar

29c. Licansa number

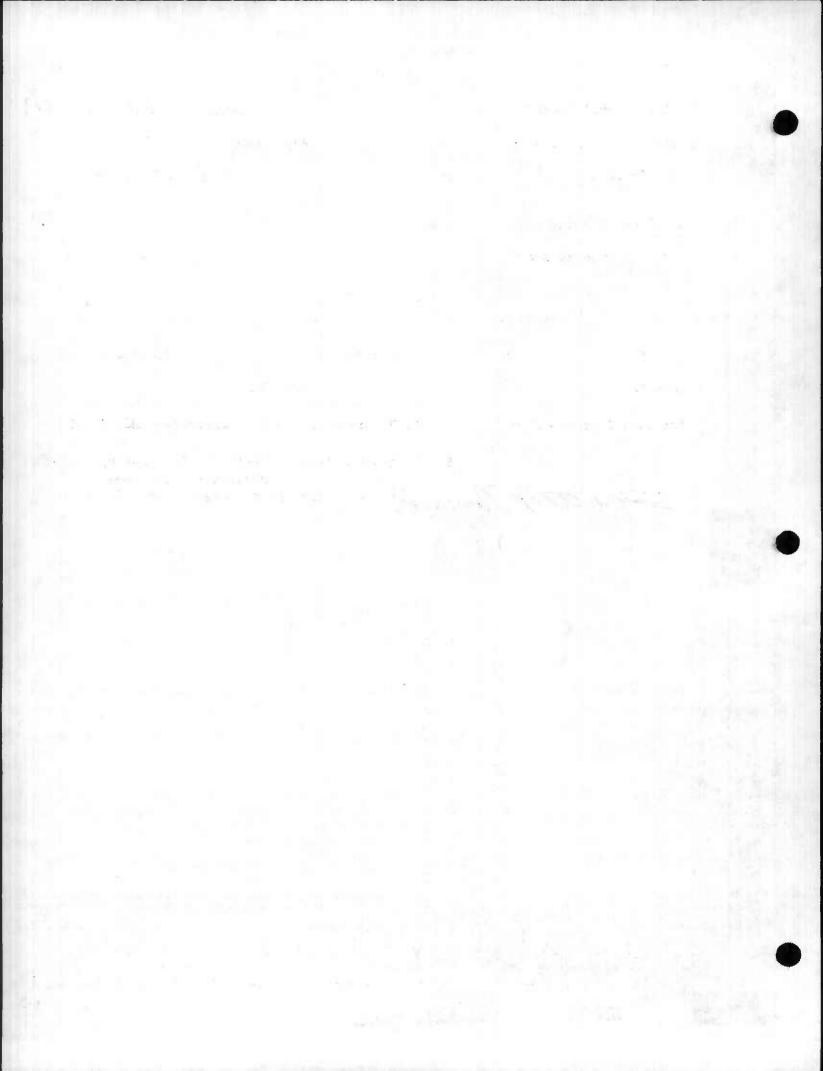
29d. Data signed (Month, Dey, Year)

Nema and address of person who completed causa of death (Item 23a) (Type, Print)

785 121 mg 1110 hadred Compai Rd Mageritown

State Registrar 31. Data filed (Month, Day, Year) JAN 09





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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia /Medic Examin	al
Funeral Director	

with the Maryland r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If item 27 is marked other than 'natural', or items 29a any Injury or other traumatic event, the Medical Exercises 200.00.

altimore, Maryland 21215-0020

Physician /Medicai Examiner

certificate be exec

Division of Vital Records, P.O. Box 68760,

210-12-1797

BERTRAM FRIEDLAND

burial-transit and physician the burial as esn for the signed by 8 page 2

this certificate has director, funeral aftar deat filled in by ŏ To the Hospital within 24 hours a To the Funeral D completely

1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Yeer Friedland Bertram 3 1998 1:00 AM **JANUARY** 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Day, Apr 19 Birthplece (State or Foreign Country)
 PA 7. Age (In yrs. lest birthday) Months X M 2 F Yrs 210-12-1797 72 Apr Ĭ925 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cumberland Yes 2 No Director Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1958 Durham Drive 21502 USA Funeral 12. Wes Decadent Ever in U,S. Armed Forces? ₱☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korean 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married 1 Yes No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced white Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Cumberland Electric Co. Retired 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Robert Friedland Ida (Schmitt) 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Melva Friedland-wife 1958 Durham Drive Cumberland MD 21502 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete H Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) East View Cemeterv 01/04 Cumberland MD 21. Signeture of Funeral Service Licanses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. anes Cumberland MD 21502 23a. Pertif Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each life. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) MALIGNANT LYMPHOMA WITH METASTASIS 4 MONTHS Due to (or es e consequenca of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Physician/Medical Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner stated. 29e. Certifier Medicai (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of 29c. License number 98 D 17920 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) NARAYAN SAHETA M.D., MEMORIAL HOSPITAL, CUMBERLAND, MD 21502

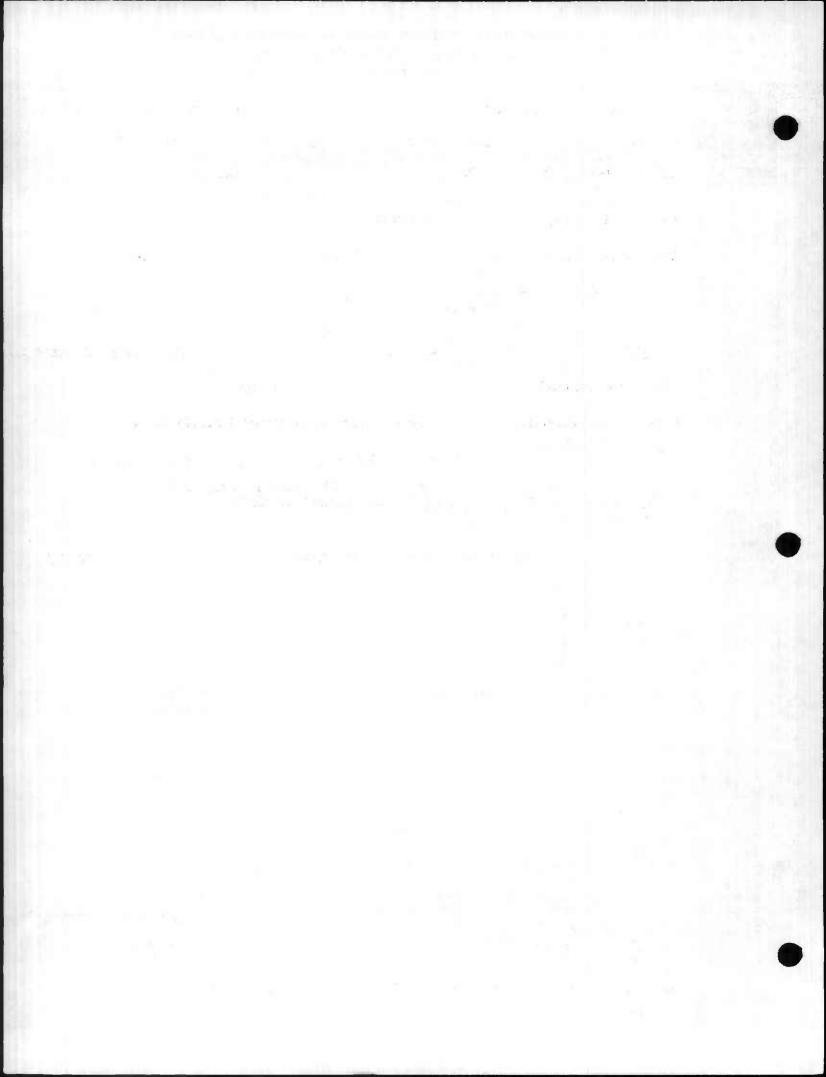
State Registrar 31. Dete filed (Month, Dey, Year) AN 0 7 199

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32. Registrer's Signeture

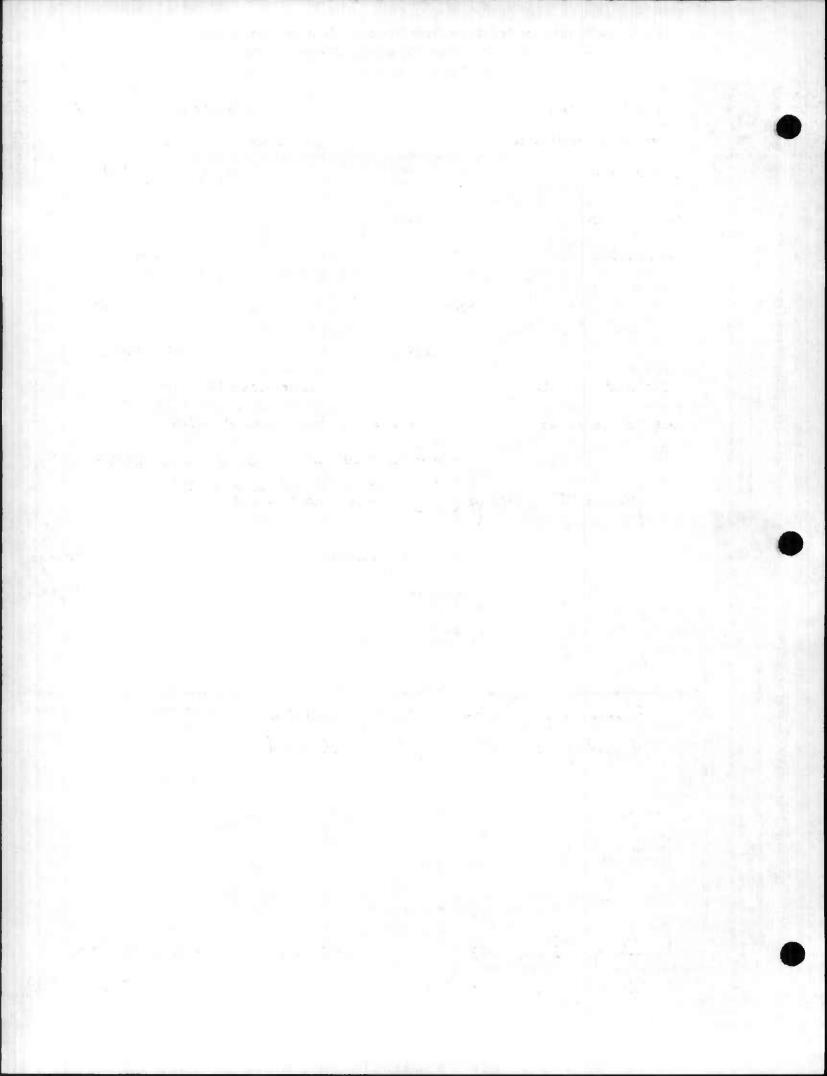
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State of Maryland / Department of Health and Mental Hygiene

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the Maryler 28s-f show	Director	WV	Mineral		Ke	yser						1 ☐ Yes 2 No
23a or 2	rai Dir	10e. Street end Nu Route 2	Box 1090			10f. Zip	Code 2672	6	10	og. Citizen of WI USA		ntry?
efter des or items	by Funeral		ried 25 Married	12. Was Decader Armed Force: 12 Yes 2 If Yes, Give Yeer or Dates	3?	13. Was Decedif Yes, special Yes		Hispenic Orlgin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		, White,	an Indien, etc. white
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should be f and Mental I marked of urnatic eve	ToB	Cliffo	ord Ray F	ord				Audra G	Saye (Gen	edum)		
d 2 should be file th end Mental Hy 7 is marked oth traumatic event		19a. Informent's N	lame/Relationship	(Type, Print)	15	9b. Mailing Address	(Street	end Number or Ru	rei Route Number,	City or Town, S	itete, Zip	Code)
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vermit. Peges 1 e Department of Hea mportant: If Item iny Injury or othe			☐ Cremetion 3 [☐Removel from Stat	8	of Disposition (Ner tery, cremetory or o	_			20c. Location - C	,	1 2 2 3 3
it. Pertant:			5 Other (Spec		Sunse	et Memori			01/12	Cumberl	and	MD
permit. Peges Department of Important: If it any injury or once.		▶ Q	unerel Service Lice	Acar	alle	Scar Cumb	pel erl	ess of Facility Li Funera and MD 21	1 Home, 1	P.A.		
		23a. Pert1. Enter shock, or he	the disease, or con ert feilure. List only	mplicetions that caus	the death. Do	o not enter the mod	le of dyi	ng, such es cardiac	or respiretory erre	est,		Approximate Intervel Between
Physiclan /Medical Examiner		Immediate Cause disease or condition	(Final			use faul	url.					Onset end Death
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uires that the dea signed by the e		Pert II. Other signi	ulmmy	contributing to death	but not resulting	in the underlying c	ful ful	ven in Pert I.	23b. Did to	. ,		the cause of death?
Peen Mou	Completed by	1	ypoly	rid er	enia	high	ch	lecteral	24a. Wes er		eve	ere eutopsy findings eileble prior to appletion of cause deeth?
The law ate has b	шо					, 0			1 ☐ Ye	s 2 No		Yes 2□ No
	Be	25. Wes case refe examiner?	rred to medical					26. Place of Dee	th (Check only on	9)		
Q 50 Z	10	1 ☐ Yes 2€	LNo	Hospitel: 100 Inpar	tient 2 ER/C	Outpatient 3 DC	Oti Oti	ner: 4 Nursing H	ome 5 Reside	nce 6 □Other	(Specif	1)
Ing Affei	lon:	27. Menner of Dea 1 ☑Natural	5 Pending	28e. Date of In (Month, D	ey Year) 28b.		8c. Inju Wo		28d. Describe ho	w Injury occurre	d	
death ctor: y the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigetion 6 Could not to	28e. Placa of I	njury - At home, etc. (Specify)	farm, street, factory		Yes 2□No	28f. Location (St. City or Town		r or Rura	l Route Number,
Hospita 24 hours Funeral tely fille	edical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	hyelclan: To the bes miner: On the basis end menner:	of examinetion e	ge, deeth occurred and/or investigation,	et the ti	me, date end piece opinion, death occu	, end due to the ca rred et the time, da	use(s) end men ite end place, er	ner es si nd due to	eted. the ceuse(s)
within 2 To the	M	29b. Signature and	title of cartifier			290	. Licens	se number	25	d. Date signed	(Month,	Dey, Year)
1		1	on (Br M	7		DI	2537	A:	anuary	11 .	1998
6		30 Name and add	ess of person who	complete cause of	death (Item 23e	(Type, Print)	- (. /	_		1 3	
gras		beo rgo	2 Brez	a MI). 4/a		20	rive C	umber	and	Me) 21502
Sta	ate	31. Dete filed	12 1998	32. Flais	trar's Signature	الخنا						1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Day Yee Sarah Lucille Gray 1998 /Medical January 12, 11:08 AM 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Hager stown Bunder 24 Hrs. 8. Data of Birth (Month, Day, May 28, Washington Washington County Hospital If Under 1 Year Months | Days 9. Birthplaca (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 1 M 2 F Days 69 Yrs. 234-46-8360 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Washington Sharpsburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3379 Harpers Ferry Road 21782 U.S.A. Funeral 12. Was Dacadent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Amaricen Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 ☐ Yas 2 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 Roy (NMI) Jenkins Elizabeth V. Hunter Zenev 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18809 Burnside Bridge Rd. Sharpsburg, MD Diane B. Harrell 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1-15-98 Sharpsburg, Maryland Mountain View Cemetery 22. Nama and Address of Facility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, it heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) theropelirales Krock Due to (or es a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed by 24h. Were eutopsy findings 04- 144----Be 2

Examiner Hospital or Attending Physician: The lew requires that the death certificate be executed
As hours effer death.
 Furnal Director: After this certificate has been signed by the ettending physicien and
eley filled in by the furneral director, page 2 should be detached for use as the burnel-trensit Division of Vital Records, P.O. Box 68760, been signed by the etter should be detached for edical Certification: • Funeral Di

_oFuneral

Director

7 is marked other than "netural", or items 23e or 28a-f show traumatic event, the Meulcal Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours efter death nent of Health and Mental Hygiene.

al Hygiene.

and Mental i

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau

Physician

/Medical

Baltimore, Maryland 21215-0020

with the Maryland

				performed?	eveileble prior to complation of cause of deeth?	
				1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	
25. Wes casa referred to medical exeminer?			28. Place of D	eeth (Check only one)		
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidant Investigati						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Numb City or Town, State)	per or Rural Routa Number,			
29a. Certifier (Check only one) 12 Certifying F	Physician: To the best of my kaminer: On the basis of exemined end manner stated.	nowledge, deeth occurr nation end/or Investigat	ed et the time, date end plac ion, in my opinion, death occ	ce, end due to the ceusa(s) end ma curred et the time, date end plece,	anner es steted. end due to the ceuse(s)	

29b. Signature end titla of certifie

29c. Licansa number D32518 29d. Date signed (Month, Day, Year) 1/13/98

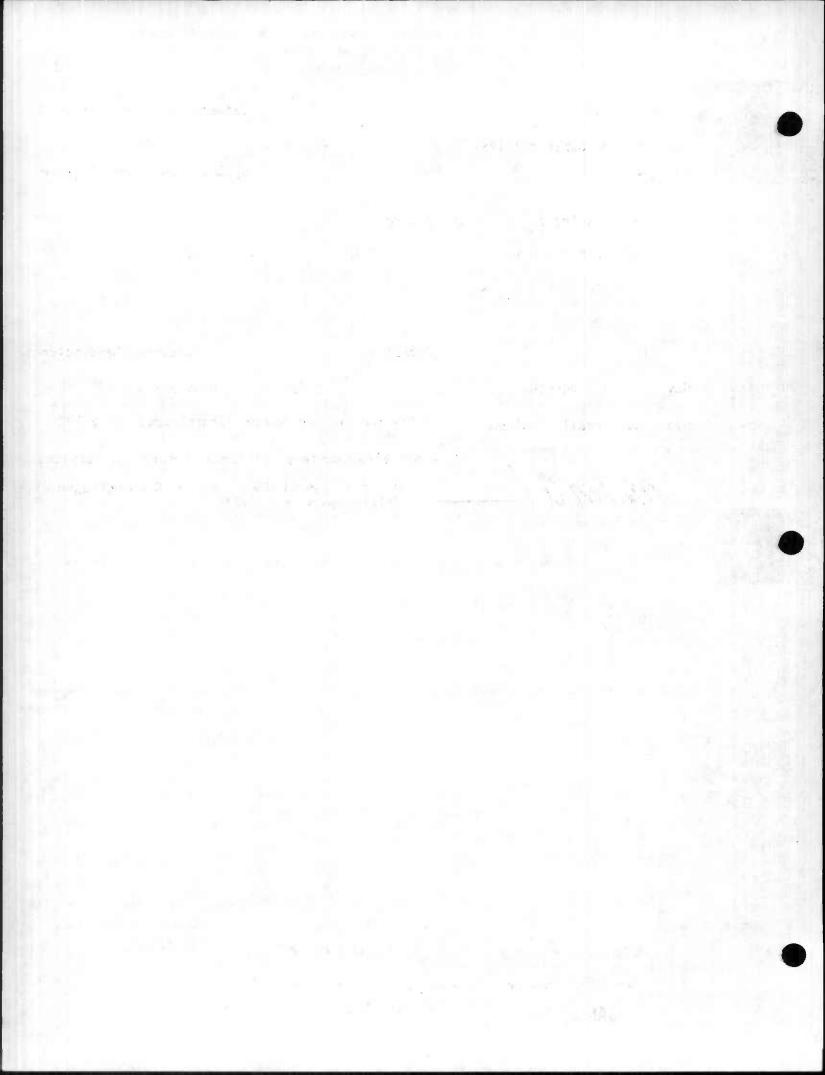
MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Geeting 21756 Keedysville Sap 31. Dete filed (Month, Day, Year)

State Registrar

32. Registrary Signary JAN 1 3 1998 who Davidson

within 24 To the F 12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medi	Ical	Carlos Alle						nuary			4:30 1	PM
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Baltimore, permit. Peges 1 er Department of Hea Important: If Nem 2 any Injury or other		21. Signatura of Funaral Servica Licer	Odi_		0sborne	Funera	Home heague	St. W	illiam	sport	, MD 21	795
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Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicida 4 Homlcida 6 Could not be detarmined	28a. Place of Inju building, etc.	ry - At homa, fam . (Spacify)	n, straat, factory, of	28f. Lo <i>Ci</i>	28f. Location (Straat and Number or Rurel Routa Number, City or Town, Steta)					
To the Hospital within 24 hours or To the Funeral I completely filled	edical	29a. Cartifier (Check only one) 1. Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the causa(s) and menner as stetad. 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the ceusa(s) and menner statad.									etad. the ceusa(s)	
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		30. Nama and address of parson who o	complated cause of de	ath (Item 23a) (T	ype, Print) 34f N	null 57	- HAE	CLSTO	wn r	nd, -	21140	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 6, 1998 6:30 a. m. Eula Lee GELWICKS January /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 754 Summit Avenue Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthpiece (State or Foreign Country) Deys 1□ M 2以 F Yrs. Director 219-20-1193 Oct. 2 1925 Alabama Usuei Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Director 1 Yes 2 □ No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 754 Summit Avenue U.S.A. 21740 Funeral 11. Marital Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. event, the Medical Examiner. permit. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mentel Hygiene. Important: if tem 27 is marked other than "natural", or the may injury or other traumatic event, the Mexical Examines and Injury or other traumatic event, the Mexical Examines once. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind ot Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be James Walker Lois 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jack A. Gelwicks 754 Summit Avenue Hagerstown, Maryland 21740 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 DOther (Specify) 1-9-98 Rest Haven Cemetery Hagerstown, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Minnich Funeral Home 15 E. Wilson Blvd. Hagerstown, Md. 21740 234 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final ZMING disease or condition resulting in death) Examiner Examiner physician and the buriel-transit The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last P.O. Box 68760, Physician/Medical for use as signed by the at Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No of Vital Records. þ Be Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause ot deeth? certificate has 1 Tyes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case reterred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 21 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 1 Yes this filled in by the funeral 27. Manner ot Deeth 1 Netural 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident s efter death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 16 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a. Certifier

29c. License number

tagerstown, Mp 21740

29d. Date signed (Month, Dey, Year)

State Registrar 29b. Signature and title of certifier

30. Name and add

31. Dete filed (Month, Dey, Julia Davidso

and the second of the second second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 6:00 pm Martha Elizabeth George 4e. Fecility Neme (If not Institution, give street end number) 1998 3 /Medical Jan 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 903 Braddock Road Allegany 9. Birthplece (Stete or Foreign Country) Cumber land If Under 1 Yeer Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 F Yrs. Director 213-24-7350 Usuel Residence of Decedent Feb 11, 1926 MD with the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryla Department of Heelth and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other treumatic event, the Medical Examiner must be not red. 1☐ Yes 2☐ No Director MD Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 903 Braddock Road 21502 13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2√2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: 16b. Kind of Business/Industry Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 2 Herman Sathoff Helen (Fitzpatrick) 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 430 Pine Place Cumberland MD 21502 20b. Pleca of Disposition (Name of cametery, crematory or other place) Dete 20c. Location Nora Blubaugh-daughter 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Mt. Herman Cemetery 01/07 Cumberland MD 21. Signature of Funeral Service License 22. Name end Address of Fecility allofus Scarpelli Funeral Home, P.A. The control of the cause of the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, if one cause on each line. 23a. Pert1. Enter the disease, or sheck, or heart failure. List Approximete Intervel Betwe Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner es e consequence of): Examiner or Attending Physician: The law requires that the death certificate be assecuted bunial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest and Due to (or es e consequence of): physician a Box 68760, Physician/Medical Due to (or es e consequence of) 88 been signed by the attandin should be datached for use 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes en autopsy performed? completion of cause of deeth? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one, exeminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Amesidence 1 Yes 2 No Certification: To 6 ☐Other (Specify) After this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 PNatural 5 Pending investigation in 24 hours efter death. he Funeral Director: Aft pletaly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es stated. Medical

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State Registrar

(Check only one)

30. Neme and addition

29b. Signeture end proportion

Gary Wagoner, M.D. 31. Dete filed (Month, Day, Yeer) JAN 0 6 1998 Bishop Walsh Drive Cumberland MD 21502

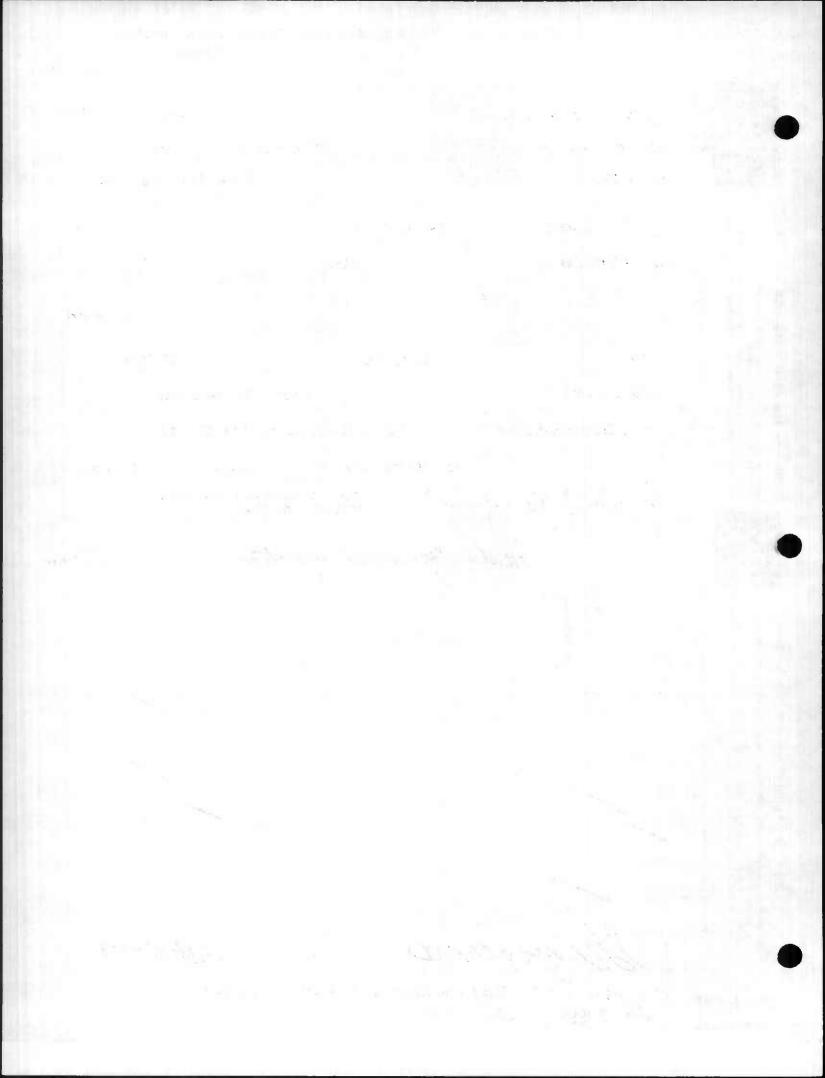
mpleted cause of deeth (Item 23a) (Type, Print)

Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

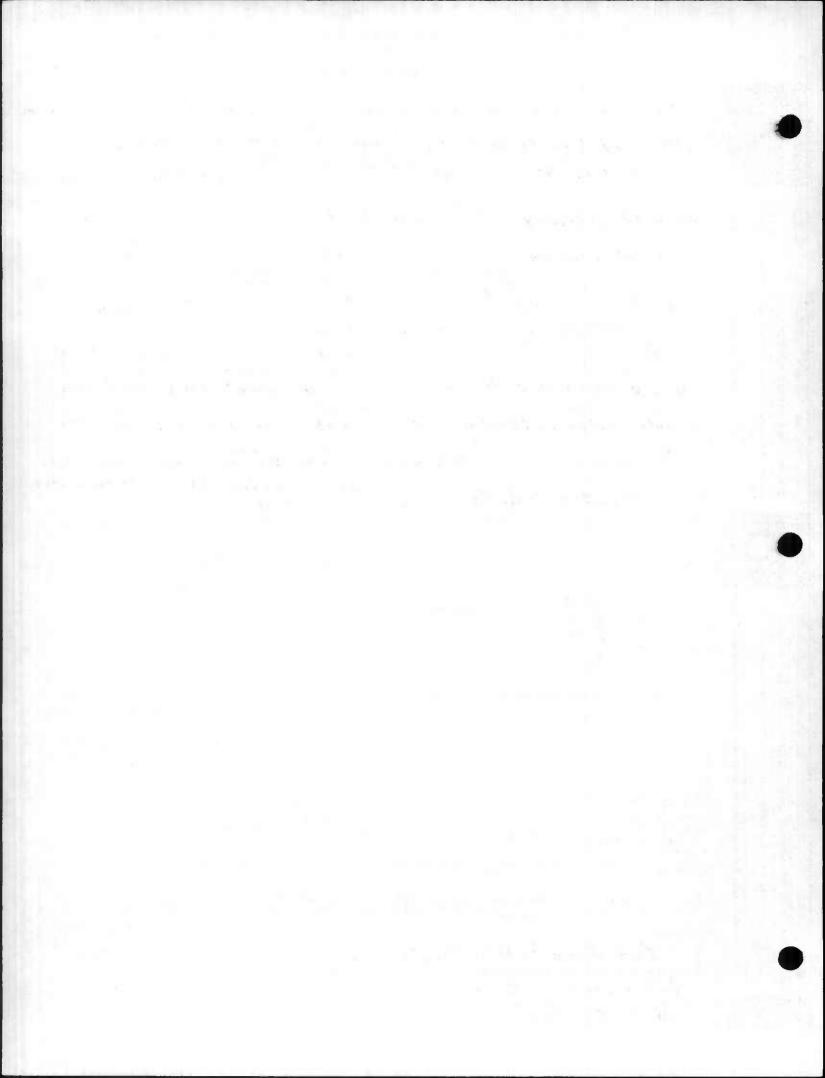
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29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene 98 0 1535

						Certifica	ate of	Death		Reg. No.	U	000			
			1. Decedent's Nema (First, Middle, Last	t)					2. Dete of D	eath		3. Time of Death			
	Physic /Medi		Leonard 1	Velson G	11/	5 1010	්		Van.	6. L	Year 998	16:150.00			
	/Medi Examil		4a. Facilify Neme (If not institution, give					4b. City, Town,	or Location of Dea			10 1 13 110			
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	Funeral		5. Social Security Number 6. Sa	7. Aga (In yrs	. last birth	day) If Un	dar i Yaar	If Under 24				ca (Stete or Foreign			
	Director		232-26-2/73	M 2□F	15 Y	rs.	is Days	Hours	May	12,1902	West	Virgini			
	pu ,		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d Inside City. Lin												
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	vith th		10e. Street end Number			10f.	Zip Coda	·		10g. Citizen of V		n			
	be filed within 72 hours after death with the Maryland tel Hygiana. d other than "naturel", or items 23a or 28a-f show event, the Medical Exeminer must be notived at	Funerai	Goldon Car					502			514				
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re,	o - = 0		20e. Method of Disposition	20b.	Plece of I	Disposition (/	Verne of	na)	Dete	20c. Location -	City or Towr	n, Stete			
Ë	0 0 - 7		1 ☑ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Ramoval from State	Con n	I CA CLIA	it Co	wotens	11,1998	runho	alound	I md.			
altimore,	pemit. Pag Department Important: It any injury o		21. Signature of Funeral Service Licans	66	/ .	22. Nama	and Addras	ss of Facility	11,1778	22- 8-	12:00	in a laws			
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	Physician		23a. Part1. Enter the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
9	/Medical														
	Examiner														
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	The law requires that the death certificate be axecuted at the scen signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	b. ————————————————————————————————————												
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	ha al	sic	Part II. Other significant conditions con	t II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I.							23b. Did tobacco use contribute to the cause of death?				
P.0	at tha da d by tha etached	Physician	chronic obstructive Lung Disagse							1 Yes 2 No 3 Probably 4 Unknow					
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ita	cartificata rector, pa	Be (25. Wes case referred to medical examiner?					28. Plece of	Deeth (Check only	one)					
2	5 00	P	1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outp	etient 3	DOA Oth	er: 4 💆 Nursir	ng Home 5 ☐ Res	idenca 6 □Oth	er (Specify)				
ח	ding Ph h. Aftar th funaral	ii.	27. Menner of Deeth 1 Neturel 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Ti	ne of ury	28c. Injun Wor	y et k?	28d. Describe	28d. Describe how Injury occurred					
Sio	Attending ir daath. ector: Aftai by tha funa	cati	2 ☐ Accident Invastigation	M 1 Yes 2 No											
Division of	or Attendiate after death	Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						28f. Location (Street and Number or Rurel Route Number, City or Town, Steta)						
	rai Dellied I	S													
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the ft	edicai	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of exemina	owledge, ation end/	deeth occurre or investigeti	ed et the tin	ne, dete end pl pinion, deeth o	lece, end due to the	ceuse(s) end me	end due to the	ed. 1e cause(s)			
	the pin 2	Med	one)	end mannar stated.			202 1222			204 Data since	100.00	- Maria			
	5 ¥ 5 ⊗		29b. Signature and title of certifiar	1 0	1		29c. Licens			29d. Date signe					
	2		Mobustiano 30. Neme end eddress of person who co	g, Iscener	-, 8	1/	D.	1486	5	Van, 8	5, 190	78			
			30. Neme end eddress of person who co	mpleted ceuse of deeth (Ite	m 23a) (T	ype, Print)	CUL	nbpnl	and, m	0.215	02				
	gred		Robustians	J. Barrel	10,	Ve,	MPU	100191	Hos	mod.	15109				
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	etura										

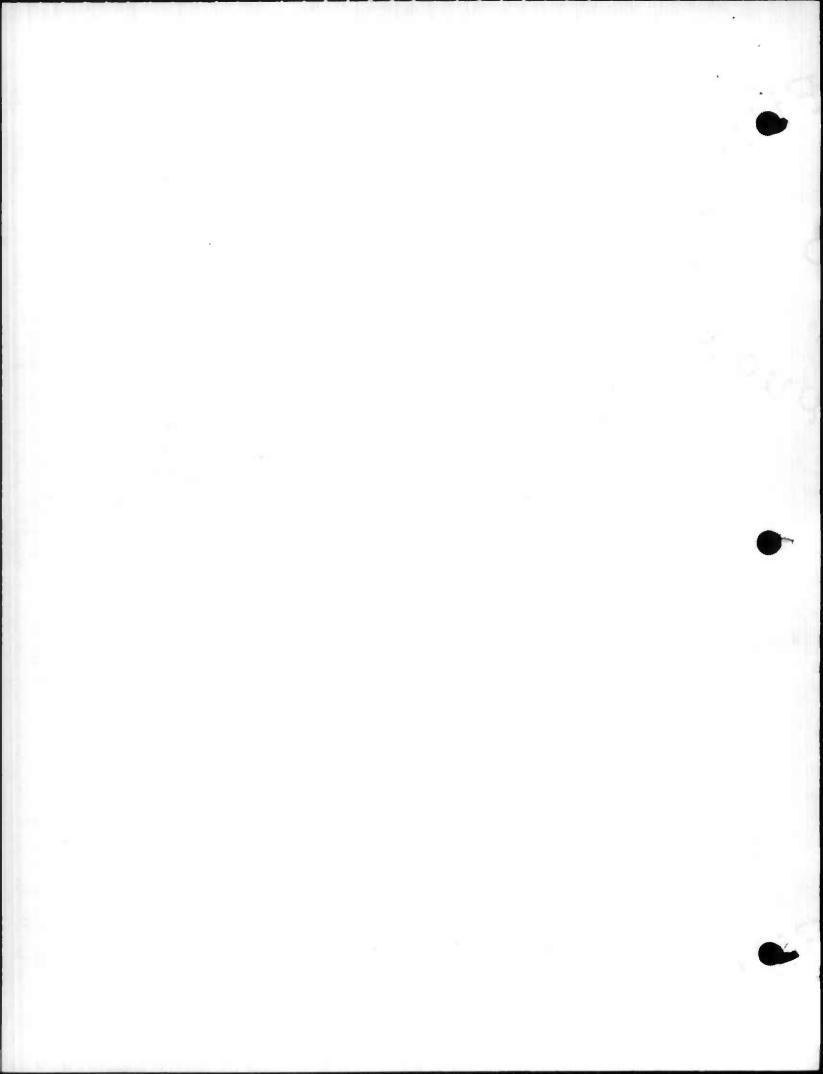


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										1000				
	1. DECEDENT'S NAME (First, Middle, Last)	The state of the s						ATE OF DEATH	3. TIME OF DEATH					
	YVONNE SHIRLEY	HAUVER					MONTH DAY			YEAR	ZMO PM			
	4. SOCIAL SECURITY NUMBER 5.		rs. last birthday)	7	IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH			PLACE (State or Foreign			
	214-32-42/3	1 □ M 2 🖾 F 62 YR		MONTHS DAYS		HOURS MIN.		Sept. 25, 1935		Maryland				
~	9e. FACILITY NAME (If not institution, give street	t end number)				LOCATION OF D	EATH			NTY OF D				
TOF	850 Noland Drive	Hag	gers	town			Was	shing	rton					
3EC	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION				ON		10d. INSIDE CITY						
FUNERAL DIRECTOR	Maryland Washin	ngton Hagerstown			1					LIMITS?				
IAL	10e. STREET AND NUMBER	10f. ZIP CODE						10g. CIT	IZEN OF W	HAT COUNTRY?				
NEF	850 Noland Drive					21740		U.S						
J.	11. MARITAL STATUS 12 1 Never Merried 2 Merried	P. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2		13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Mexican						— American Indien,				
ВУ	3 Wildowed 4 Divorced	F YES, GIVE WAR OR DATES 1 ☐ YES 2 X NO Speci				fy:			Speci	White				
ED	15. DECEDENT'S EDUCATION	ION 16s	16s. DECEDENT'S USUAL OCCUPATION					16b. KIND OF BUS	DUSTRY	WIIICE				
E		College (1-4 or 5+)	se retired.)											
MPI	12	Data Entry						County (nmen	nment				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						IAME (First, Middle, Maiden Surname)							
BE	Cletus E. Bowlus 190. INFORMANT'S NAME (Type/Print)							e Riden						
0	Deborah A. Everhart	/Daughter				Number or Rural Street		lumber, City or Town			and 21742			
	20a. METHOD OF DISPOSITION							agersto						
	1 - Buriel 2 - Cremation 3 - Removal from State completer, cremation or other place)													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown,									21742				
	23. PARTI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest.													
	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death													
											(
	resulting in death) a. DUE,TO (OR AS A CONSEQUENCE OF): DUE,TO (OR AS A CONSEQUENCE OF):													
NO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
ATI														
임	CAUSE (Disesse or Injury that initisted events	DUE TO (OR AS A CO	NSEQUENCE OF	7):							-			
CERTIFICATION	resulting in daeth) LAST													
	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
CAL	PERFORMED? CAMBLET													
0								1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?			
2	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	EATH YE	S D N	οП	UNCERTAIL	ΝП				1 TYES 2 NO			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	26. 1	PLACE OF DEAT			-								
SIC	EXAMINER? 1 YES 2 MO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)													
F	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 1NJURY AT WORK?					26d. DEŞCRIBE HOW INJURY OCCURED							
BY	1 Natural 5 Pending 2 Accident Investigation	N. M.			M 1 YES 2 NO									
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	4 Homicide determined													
MP	(Check only T in CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.													
	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER													
H	29c. LICENSE NUMBER 29d. DATE SIGNED (Mon										(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF DEATH	(ITEM 27) (Type.	Print)		U 67	00			1114148				
4	Frederic H. Kas			ical	Car	pus R.	1.	Maner	حاصل	wn MD 21742				
	31. DATE FILED (Month, Day, Year)	32 DEGISTRADIS SIGNATUR	DE				1 1		111111111111111111111111111111111111111					
JAN 1 5 1998 Julia Davidson-Randson														

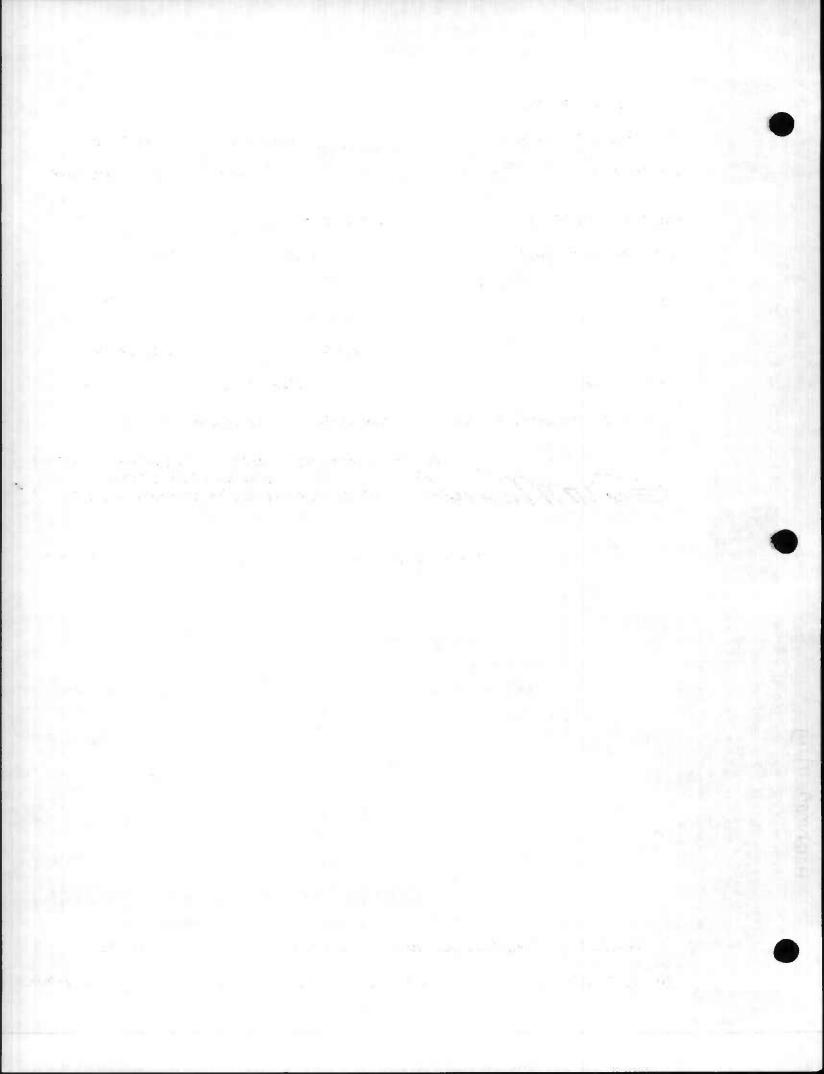


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Vaar **Physician** MARGARET IRENE HOOVER 1998 January 2:15 a.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 12124 Palisades Drive
5. Social Security Number 6. Sax Dunkirk If Undar 24 Hrs. Calvert If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F Yrs. 52 Director 577 62 8934 April 15,1945 Maryland Usual Rasidence of Dacedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d, Insida Cltv Limits the Medical Examiner must be notified at Director 1 ☐ Yas 2 No Maryland Calvert Dunkirk 10e. Straat and Number 10g. Citizan of What Country? 10f. Zip Code 0 12124 Palisades Drive 20754 USA Нете 23а pemit. Pages 1 and 2 should be filed within 72 hours efter death v. Department of Health and Mentel Hygiene. Important: If itam 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner muses once. Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 287 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iffa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 18b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) teacher's aide education 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Bernard Hunter Walters Grace Irene 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) <u>Stephen L. Hoover / spouse</u> same as # 10 above 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1
☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1-9-98 4 ☐ Donation 5 ☐ Othar (Specify) Barnabas Ch. Cem. Temple Hills, MD 21. Signature of Funarai Sarvice Licensee 22. Nama and Addrass of Facility M Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complice on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can also an each line. Approximata Intarval Batwe **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medical Stomach 15 Months Examiner Dua to (or as a consequance of) Examiner physicien and s the buriel-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): signed by the attending be detached for use as use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Wera autopsy findings available prior to complation of cause of death? pege 2 should Completed 24a. Was an autopsy performed? certificate has 1 Yas 2 No 1 Yas 2 No or Attending Physician: funeral director, Be 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation within 24 hours efter death. To the Funeral Director: A 2 Accidant 1 ☐ Yas 2 ☐ No the 3 Suicida 6 ☐ Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian completely (Check only one) å, 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licensa number 30. Name and eddrass of person who complated cause of death (Itam 23a) (Type, Print) 10 Prince Fro derick MAD 20 120 Hes 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State This Studen Reveal Registrar

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Day Mary Elizabeth HARSHMAN 1998 Dun 13 /Medical 4c. County of Death 4a. Fecility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Deeth **Examiner** Washington County Hospital Hagerstown Washington If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. lest birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpleca (Stata or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 ☒ F Yrs. 85 Director 220-16-2968 Nov. 24, 1912 Maryland Usual Residence of Dacedent the Maryland 10e. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits other traumatic event, the Medical Examiner naun be notified at Director N☐ Yes 2☐ No 28a-f Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? ò 340 Devonshire Road items 23a 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black. White, etc. 1 Never Marriad 2 Married 3altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2♥ No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry e filed within 7. al Hygiene. f other than "n Elementery/Secondary (0-12) College (1-4or 5+) clerk 8 retail sales 0 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic avena-17. Father's Neme (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be Norman Reese Lizzy Irwin 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert L. Harshman, Sr.-son 308 Wakefield Rd., Hagerstown, Md. 21740 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery 1-16-98 Hagerstown, Maryland 22. Name and Address of Fecility MINNICH FUNERAL HOME 21. Signature of Europet Service Licenses unud 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immadiate Ceuse (Final disease or condition resulting in death) /Medical Meute Leckemia 1 week Examiner Due to (or es a consequence of): Examiner Sequantially list conditions, if any, leading to Immadiate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest attending physician and for use as the bunal-trar Due to (or as a consequenca of): Box 68760 certificate be Physician/Medicai Dua to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy parformed? Completed page 2 hes this certificate 1 Vas 2 □ No 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical exeminar? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpetiant 3 ☐ DOA 27. Menner of Death Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun or Attending 1 Naturel Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner es steted.
2 Medical Exeminer: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medical 29a, Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) melanal Mo 1.13.98 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) McCornack 11110 Medied Canyos Fel. Svite 130 thoses hun, ND 21742 Michael 31. Dete filed (Month, Day, Yeer)
JAN 1 4 1998 32. Registrar's Signature State Gulia Davidson Randelle Registrar

tarshman, Mary



State of Maryland / Department of Health and Mental Hygiene |

0 | 539 Certificate of Death 2. Dete of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Veer **Physician** Margaret Norma Hayes 2036 Jan /Medical 10 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 20XF 120-22-4816 67 Yrs. Marilland Director Usual Residence of Decedent tha Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits I is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at Md. Washington Hagerstown 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after daath with 21740 U.S.A. 352 S. Potomac St. Funeral 12. Was Decadent Ever in U,S. Armed Forces?
1 1 Yes 2 2 No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Care Person Nursing Home permit. Pagas 1 and 2 should be file Department of Haalth and Mantel Hy Important: If item 27 Is marked othe any injury or other traumatic event, 906.6. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Devonna Caroline Hornbecker Senor Reisher Everetts 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Friend) 352 S. Potomac St. Hagerstown. Md. 21740 Robert Artz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Reproval from St Jan. 12, 1998 Smithsburg, Md. Smithsburg Crematory 21. Signeture of Funeral Service Licans 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 ennis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician /Medicai Immediate Cause (Final disease or condition resulting in death) . Asterio schotic Condia unacha Diseu Examiner Due to (or as a consequenca of) Physician/Medical Examine The law requires that the death cartificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy findings Completed 24a. Was en eutopsy peen s evailable prior to completion of cause of death? performed? hes a 2 s 1 | Yes 2 | 110 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 ☐ Inpatient 2 ☐ CA/Outpatient 3 ☐ DOA \$ 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? I Director: Aftar ti d in by tha funera Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural daath. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aff To the Funerel Di complataly filled in 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) and manner as stated.

2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signeture 29c. License number 29d. Dete signed (Month, Day, Year) . QW. BiHops o Jan 11, 1995 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 217 W. Washington St. Hagerstown, Md. 21740 Edward W. Ditto III M.D. 2 199832. Registrate signature Juridson-Rendelle State Registrar

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Show the six of my 30-120 C The 1/1/1/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month January VTVTAN JANE HULLINGER 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington County Hospital Washington Hagerstown Months Days Hours Min. Nov. 9, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2X F 220-28-3966 63 Yrs. 1934 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Washington 1 ☐ Yes 2 K No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18539 Orchard Hills Parkway 21742 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2X No Specify: White Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John B. Weaver Olive E. Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Hullinger/ Husband 18539 Orchard Hills Parkway Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RestHaven Cemetery Jan. 10, 1998 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagers att. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, occ, or heart failure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Part1 Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) · Metastatic Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or es a consequence of) Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

that the deeth certificate be executed P.O. Box 68760, Vivian The law requires Division of Vital or Attending Physician: To the Hospital or Attendir within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu death.

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Peges 1 end 2 should be filed within 72 hours after death with the Marylan nent of Health end Mental Hygiene. Int: If Item 27 is marked other then "netural, or items 23a or 28a4 show ary or other traumatic event, the Med cal Exame mant be nothing at

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Baltimore, Maryland 21215-0020

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State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end manner stated. 29b. Signature and title of certifier gan

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29c. License number

29d. Date signed (Month, Day, Year) Junuary

MAR 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

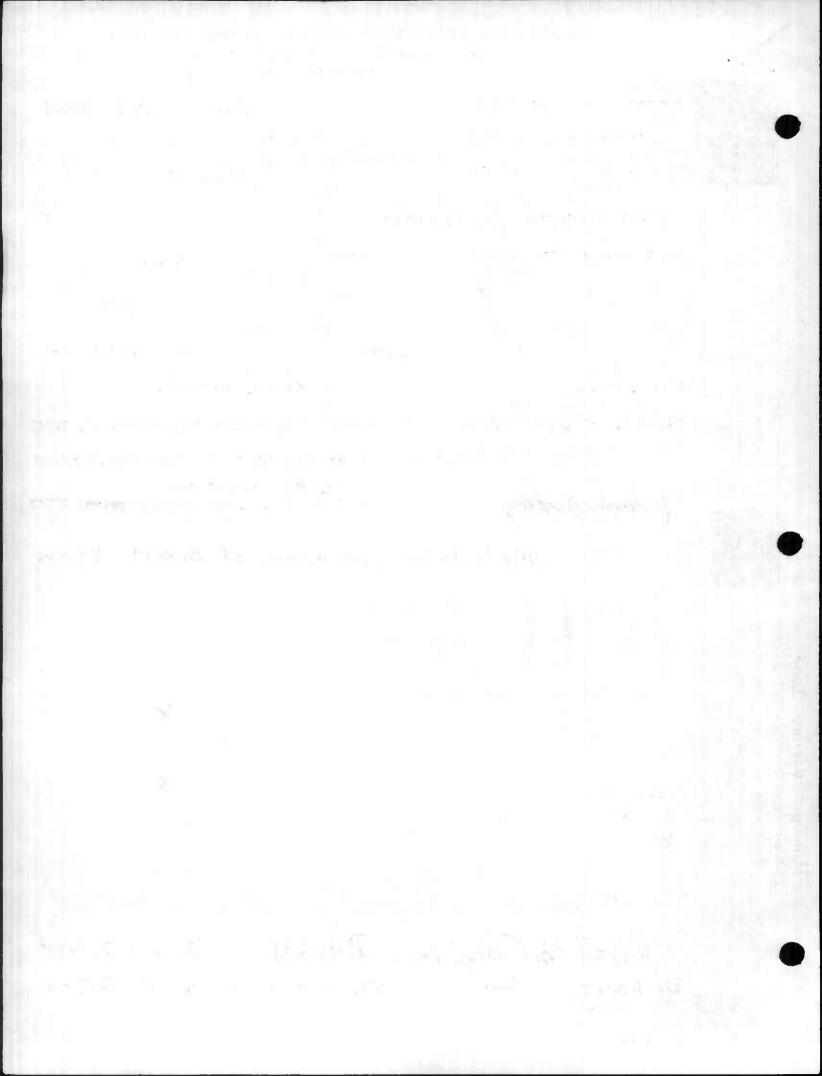
Dr. Albert 31. Date filed (Mohin, Pay (199) 1998

4 Homicide

(Check only one)

29a. Certifie

370 Mill Street Hag. Nd. 21740 32. Redistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month ROBERT CECIT. **HOFFMAN** 1998 January 110 pm 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death 500 Indiana Avenue Hagerstown Washington 5. Social Security Number 7. Age (In vrs. last birthdev) If Undar 24 Hrs. 8. Deta of Birth (Month, Dey, Year) May 23, 1923 9. Birthpiece (State or Foreign Country) Florida 10XM 2□ F Months Deys 74 Yrs. 262-24-9349 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington 1 √Yas 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Indiana Avenue 21740 U.S.A. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian Bleck, White, etc. 1 XYes 2 No If Yes, Give Year or Detes: 1943to46 1 Never Married 2 Married 1 Ves 2 No Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Owner / Operator Resturaunt 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme, Anson Ellesmere Hoffman Annie Maude Harbour 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia S. koontz/ Daughter 20824 Red-Glo Lane Hagerstown, Maryland 21740 20a, Method of Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery Jan. 10, 1998 Hagerstown, Maryland 21. Signeture of Funerel Sarvice Licensea 22. Nama and Address of Facility Douglas A. Fiery Funeral Home 1331 Fastern Blvd. N. Hagerstown, Maryland 21742 reuclos A. 23a. Fart1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on sech line. Approximete Intervel Between Onset end Death Immadiate Ceuse (Finel disease or condition resulting in deeth) Months MINO Due to (or es e consequence of):

Physiclan /Medical Examiner

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permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Manylan Department of Health and Mantal Hygiana. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinas must be notified at

Baltimore, Maryland 21215-0020

niner nding physician and usa as tha bunal-transit for sign d ba paga 2 funaral director, s eftar daath. tha

or Attending Physician: The law requires that the deeth cartificeta be axecuted

Division of Vital Records, P.O. Box 68760,

29b. Signeture and title of cert

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

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132. Registrars Signature

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State Registrar

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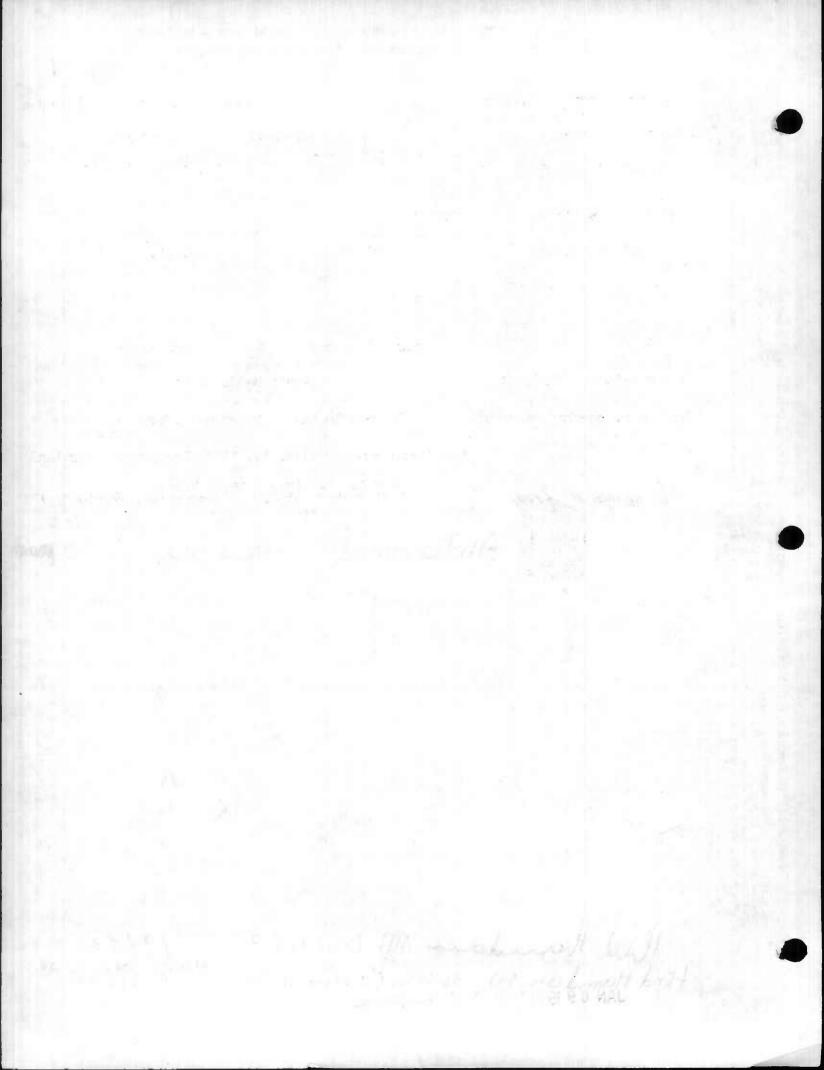
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Sequentially list con if eny, leeding to impose. Enter Under Ceuse (Diseese or in the timitiated events	madiate	Due to (or es a consequence of):											
thet initiated events resulting in deeth) L	est	Dua to (or as e consequance of):											
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Pert II. Other algnific	cant conditions c	ontributing to death but not re	sulting In tha underlying	cause given in Pert I.	23b. Did tobacco uee co	ontribute to the cause of deeth?							
					24a. Was en eutopsy performad?	24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1 Yes 2 No							
25. Wes cese rafarre	ed to medical			26. Place of De	eth (Check only one)								
exeminer? 1 Yes 2 N	No	Hospital: 1 Inpatient 2	ER/Outpetient 3□ [OOA Other: 4 Nursing	Home 5 Raşldence 6 □Ott	ner (Specify)							
27. Menner of Death 1 Natural 2 Accident	5 Pending Investigation		28b. Time of Injury	28c. Injury et Work? 1 ☐ Yas 2 ☐ No	28d. Describe how injury occur	rred							
3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined	28e. Piece of Injury - At h building, etc. (Spaci	nome, farm, street, factory)	28f. Location (Street end Number or Rurel Routa Number, City or Town, State)									
29e. Cartifiar (Check only one)	1☐ Certifying Ph 2☐ Medicat Exem	yalclan: To the best of my kno niner: On the besis of examine and menner steted.	owledge, deeth occurre ation end/or investigation	d at the time, date end plec n, in my opinion, deeth occ	e, end due to the ceuse(s) end mourred et the time, dete end place,	enner es steted. end due to the ceuse(s)							

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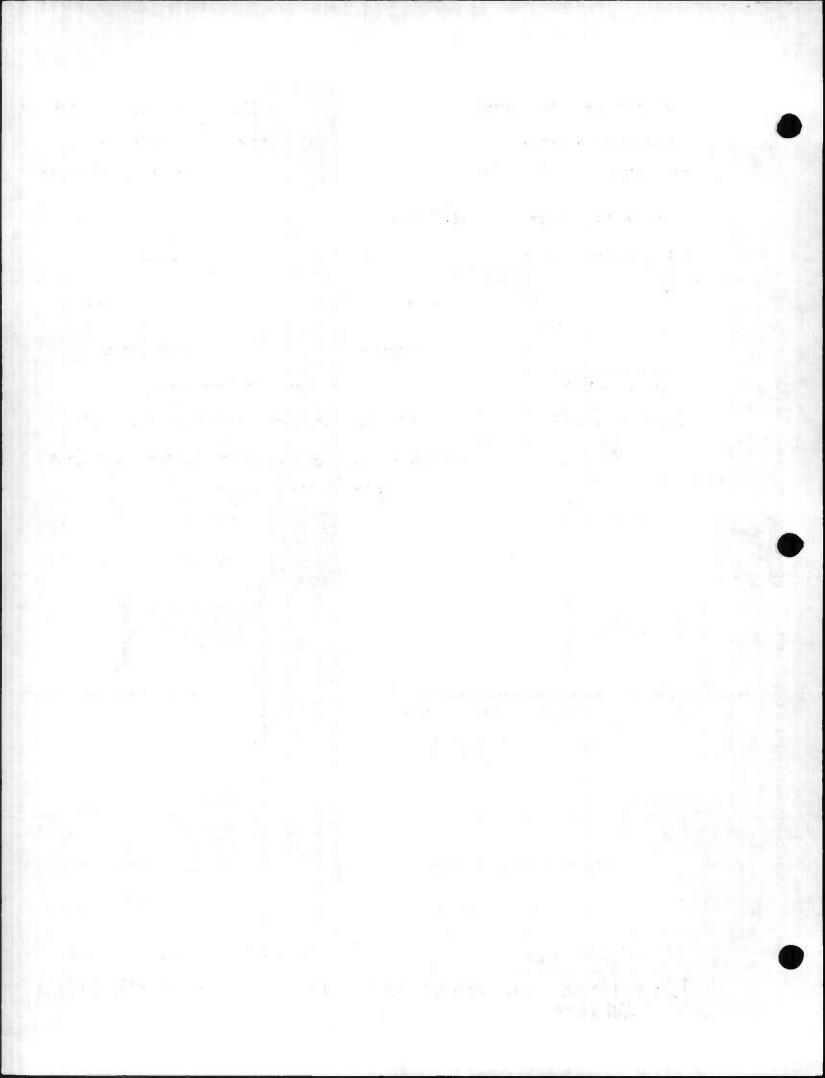
29d. Data signed (Month, Dey, Yaar)



State of Maryland / Department of Health and Mental Hygiene

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ician	Decedent's Name (First, Michael 1. Decedent)	Idle, Last)						2. Date of De	ath Day	Year	3. Time of De
dical	WILLIAM ALEX							Januar			1:57
niner	4a. Facility Nama (If not institut	OV IT	27.5					cation of Deat	4c. County	of Death	
	Williamsport	-				Willi	-	ort	Washi		
al	5. Social Security Number	6. Sax 1⊠ M 2□ F		yrs. last birthday) If Undar 1 Ya Months Da		24 Hrs. Min.	8. Data of Bir Month, Da	th ly Year)	9. Birthp	piaca (State or Fontry) nsylvani
or	194-10-2290		83	Yrs.				Jun. 1	8,1914	Penn	isy Lvani
	Usual Residence of Decedent 10a. Stata 10b. Cour	ity	100	c. City, Town or L	ocation					1	10d. inside City L
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Director	10e. Street and Number 10f. Zip Code								10g. Citizen of	What Cour	ntn/2
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Completed by	Armed Forcas? If Yas, specify Cuban, M 1 ★ Naver Married 2 Married 1 ★ Yes 2 No							Rican, atc.)	Bla	ck, Whita,	
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		4		Engi	neer				Steel (Compar	ny
Be	17. Father's Name (First, Middl								Maiden Suman		
2	Adam J. Hazle					nel M	ithero	w Skelly	<u> </u>		
	19a. informant's Name/Relationship (<i>Type, Print</i>) Warner Marshall/Cousin 19b. Mailing Address (<i>Street and Nur</i> 13224 Dawnwood Co										
		11/Cousin		0b. Place of Disp			irt		thian Va		
	20a. Method of Disposition 1 Disposition 2 Cremation	į	Date	20c. Location -							
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l r	Immediate Cause (Final disease or condition Precumonia										48 lan.
	resulting in death) Due to (or as a consequence of):										
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niner		b	Due		equence of):			= 71			10 prem
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cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due	to (or as a conse	quence of):						10 prem
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mildred Geraldine HUGGIN 001 Jan 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 20, Hagerstown Washington 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1□ M 21XF 220-58-2819 88 Yrs. 1909 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1134 Glenside Avenue 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married white 1 ☐ Yes 2 ☒ No Specify: Specify 3 ₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-12 College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Russel Froehlich Anna Mabel Maus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Phyllis H. Nunamaker/Daughter 306 Lannafield Drive, Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6,1998 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 much 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardine Due to (or as a consequence of): artery disease Due to (or as a consequence of): dirtress due to aspiration Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dementra 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 20 No 1 Yes 20 No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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"natural", or Items 23a

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other traumatic evant, are Med once.

72 hours after

Baltimore, Maryland 21215-0020

Director

Funerai

by

Completed

traumatic evant, the Medical Examiner must be notified at

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

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Completed

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Certification: To

Athar Attending

or Attend after death Director:

To the Hospital of within 24 hours at To the Funeral D

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year)

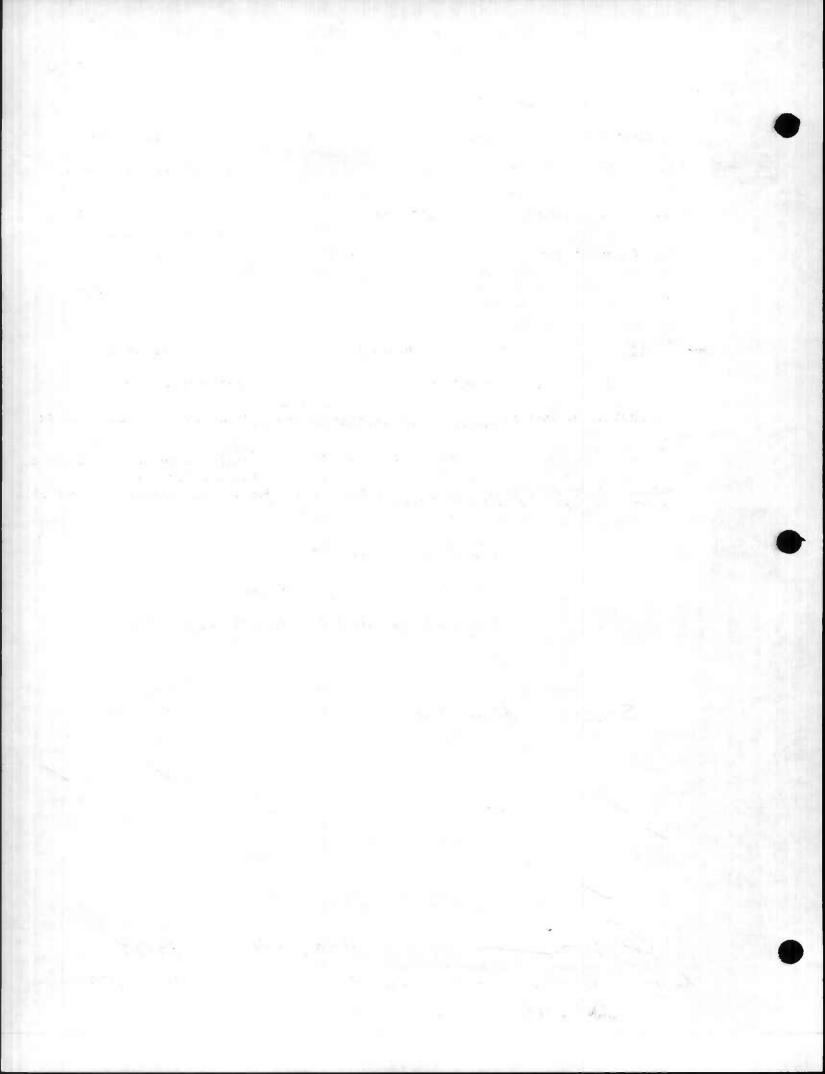
State Registrar

31. Date filed (Month, Day, Year) JAN 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenspain, High St. Hancak, Md. 21750 m.D. - 130 W. 32. Registrar's Signature Julia Davidson

Division of Vital Records,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Dey 3 Margaret E. Hamilton JANUARY 1998 10:30 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND
If Under 24 Hrs. ALLEGANY If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Birthplece (Stete or Foreign Country) Deys Hours 1□ M 2√2 F Director Yrs 223-46-8227 87 August 19, 1910 MD Usuel Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 □ No Allegany Lonaconing 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death v 15 E. Main Street Funeral 21539 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack. White, etc. filed within 72 hours eftar 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) Education 12 5 Teacher 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Robert Hamilton 2 Mary Schaefer 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1020 Weires Avenue LaVale, MD 21502 Robert Hamilton Nephew 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Jan. 6, 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak Hill Cemetery 1998 Lonaconing, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility McKenzie Eichhorn-McKenzie Funeral Home 23a. Part1 Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 9, shock, or heer feiture. List only one ceuse on each line. MD 21539 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Neumonia Examiner Due to (or es e consequence of): burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting In deeth) Lest and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, attanding physician Physician/Medical the Due to (or es e consequence of) 98 usa Po Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Dld tobecco use contribute to the cause of death? signed by t 1 ☐ Yee 2X No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? peen has page 2 this cartificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No MARGARET HAMILTON Hospital or Attanding Physician: director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Inpatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural daath. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) after 4 Homicide within 24 hours a 29a. Certifier 😢 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end manner stated. To the 295. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D 28910 10

MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD

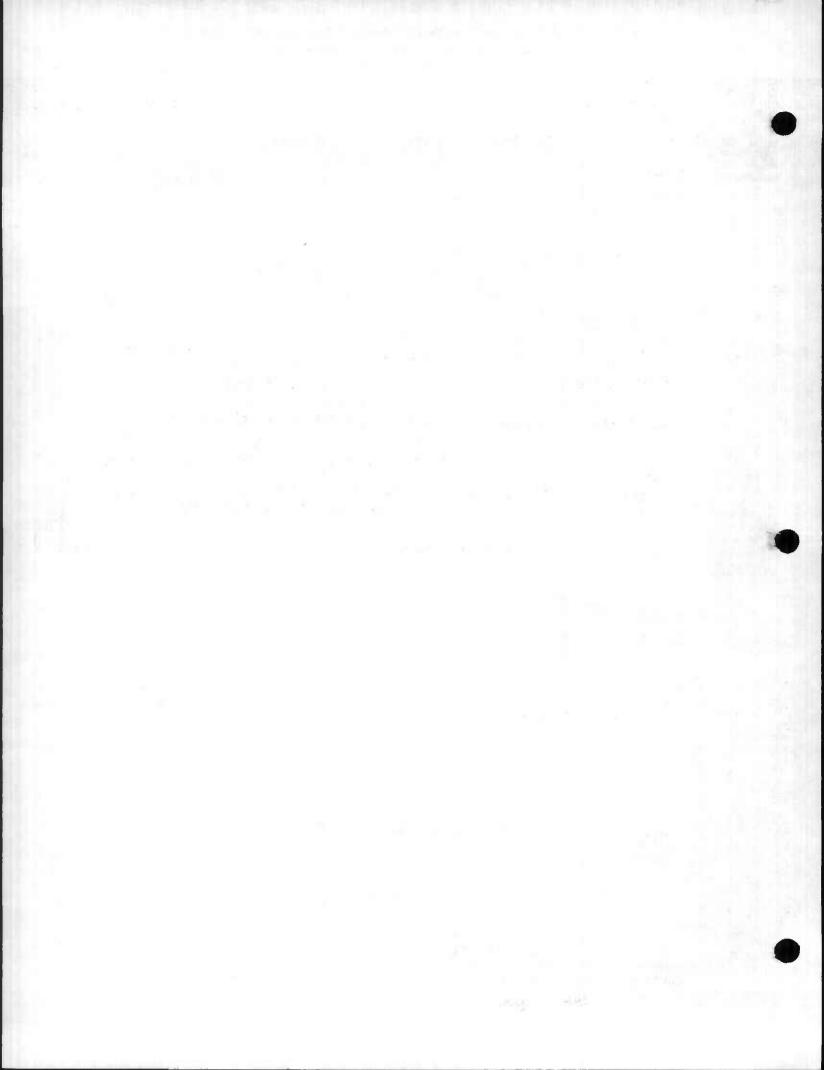
State Registrar 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

08

1998 Registrar's Signature

CURTISS MERRICK M.D.,

Oke



State of Maryland / Department of Health and Mental Hygiene

				C	Certifica	te of	Death			Reg. No.	U	1949		
Physician		1. Decedent's Name (First, Middle	, Last)		NE II				2. Date of De		Yeer	3. Time of Deeth		
Medical/		SYLVIA F.	JONES						ANUAR	Y 9, 19	998	17:55 P ₁		
Examiner	1	4e. Facility Name (If not institution Calvert Mem		ital					ation of Deet					
		5. Social Security Number		(In yrs. lest birtho	four If Und	er 1 Yea			rederi		Calve:			
uneral rector		226-40-0366 Usual Residence of Decedent	1 M 2 M F	64 Yrs	Months			Min.	Oct. 1	th Yeer 1933	9. Birthbi	lace (Stete or Foreign try) irginia		
"natural", or items 23a or 28a-f show ledical Examiner must be notified at ledical Examiner must be notified at ledical by Funeral Director		10a. State 10b. County 10c. City, Town or Location									1(Od. Inside City Limits		
cto		Maryland Calve	ert	Hunt	ingtow	n						1 ☐ Yes 2 💹 No		
Dire		10e. Street and Number				ip Code				10g. Citizen of		try?		
ra is	3	515 Armiger Roa				0639					USA			
by Funeral Directo	2	11. Marital Status 1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent El Armed Forces? ed 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:		13. Was Dec If Yes, sp 1 ☐ Yes	ecify Cul	oan, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)	Blad	e - America ck, White, e v: Blac	etc.		
Completed	3	15. Decedent	s Education		ecedent's Us			at and somewhalm		16b. Kind of B	usiness/Ind	lustry		
Medical Exami		(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+	·) 18	live kind of w e. DO NOT	use retire	ed)	t of workin	g	Doord	of Da	ucation		
Co	5	12	1	Se	ecreta	ry 5				board	or Ed	ucation		
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		19a. Informant's Name/Relationsh Jean Gray/Daught							er, City or Town, D 20639	Stete, Zip	Code)			
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	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 2067													
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e as the burial-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):												
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2 should					Ц.					an eutopsy ormed?	eve	ere autopsy findings eilable prior to appletion of cause deeth?		
Com									1 🗆	Yes 20 No	1	Yes 2000		
director, pag		25. Was case referred to medical examiner?					26. Place	of Death	ath (Check only one)					
	-	1 ☐ Yes 2 No	Hospital: 1 Inpatient			UM	_			dence 6 □Oth		•)		
uo uo		27. Manner of Death 1 Natural 5 Pending 2 Accident Investige 3 Suicide 6 Could no	ation of the	Year) Inju	28b. Time of Injury et Work? M 28c. Injury et Work? 1 Yes 2 No									
led in by the f		4 Homicide determine	building, etc.	(Specify)		set, fectory, office 28f. Location (Street end Number or Rural Route N City or Town, Stete)								
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E CO		29b. Signature and tale of certifier		0 0		-	se number			29d. Dete signe				
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nd 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Nora 98 35°PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Days NUYSING 7. Aga (In yrs. lest birthday) If Under 1 Ye
Months Da enne MN D GUVVE Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Number Birthplace (Steta or Foraign Country)
 MD **Funeral** Yaar) Davs 1□M 2₽F Hours Yrs **Director** Jun 18, 218-30-0339 with the Marylend 10a. State 10b. County 10c. City, Town or Location Itams 23a or 28a-f show 10d. Insida City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yas 2 XNo Cumberland MD Allegany 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mentel Hygiene. Important: if Itam 27 is merked other than "natural", or Itams 23s any Injury or other trauments and Injury or other trauments and Injury or other trauments. USA Funeral 1 Miltenberger 21502 Place 12. Was Dacedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritel Status 14. Race - American Indian. Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaer or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify 3 ☐ Widowad 4 ☐ Divorcad white Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Surname) Be P Bessie Via (Whitacre) William James Luckey 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Route Numbar, City or Town, State, Zip Coda) 1 Miltenberger Place Cumberland MD 21502 Ellen Baker-daughter
20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, crametory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donetlon 5 □ Othar (Spacify) Sunset Memorial Park Cumberland MD 01/11 22. Nama and Addrass of Facility 21. Signeture of Funaral Service Licensaa Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part 1. Inter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximata intervel Batwaan Onset and Death **Physician** Immediate Ceusa (Final disaesa or condition rasulting in daath) /Medical Lyears Examiner Physician/Medical Examiner signed by the ettending physician end id be deteched for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated events rasulting in deeth) Last Due to (or es e consequança of): Division of Vital Records, P.O. Box 68760. Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were eutopsy findings eveilabla prior to complation of cause of death? 24a. Was an autopsy performed? hetes After this certificate has 2 No 1 Tas 1 ☐ Yas 2 ☐ No Be 25. Wes casa referred to medical examinar? 26. Place of Death (Check only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: Nursing Home 5 Assidance 6 Othar (Spacify) Certification: To 1 Yas 2 No 28e. Data of Injury (Month, Day Yaar) 27. Mannar of Daath 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1) Naturel 5 Panding deeth. Investigation 1 ☐ Yas 2 ☐ No 2 Accidant To the Hospital or Attend within 24 hours efter deeth To the Funeral Director: in by the 3 Sulcida 6 Could not be datamined 28a. Place of Injury - At homa, farm, straat, factory, office building, afc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida Cartifying Phyeician: To tha bast of my knowledga, daath occurred et the tima, data and pleca, end dua to tha causa(s) end mennar es statad.

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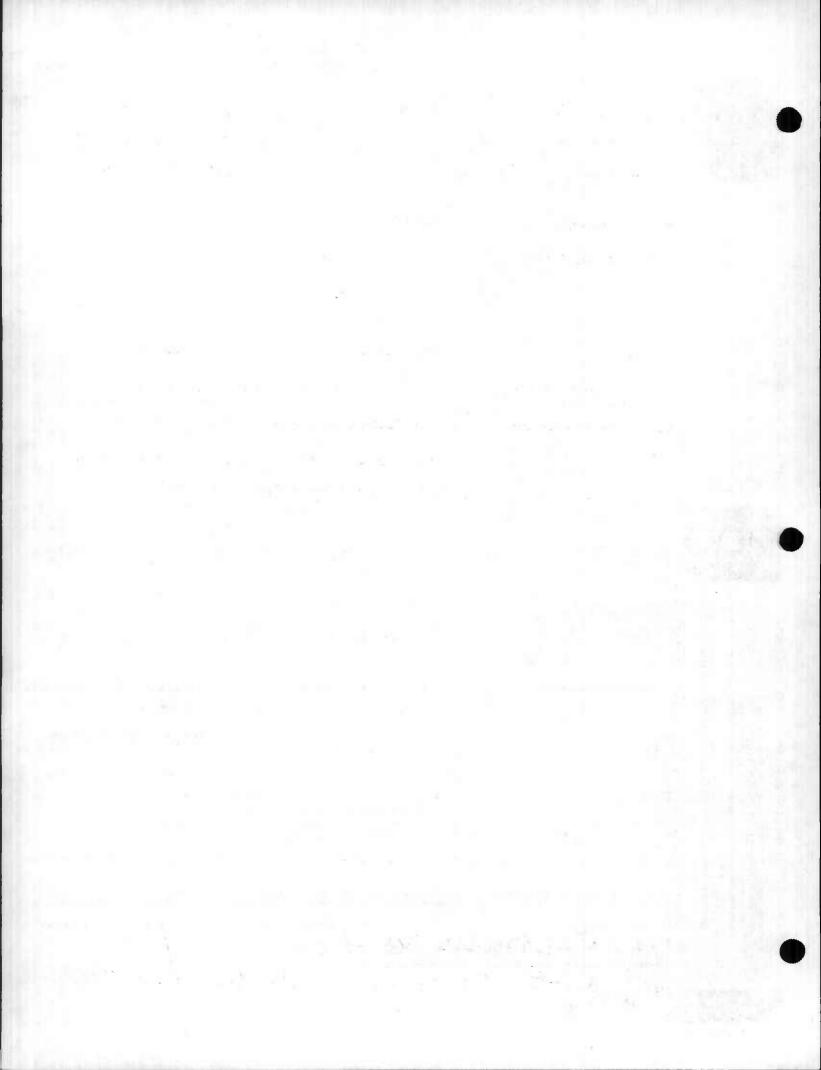
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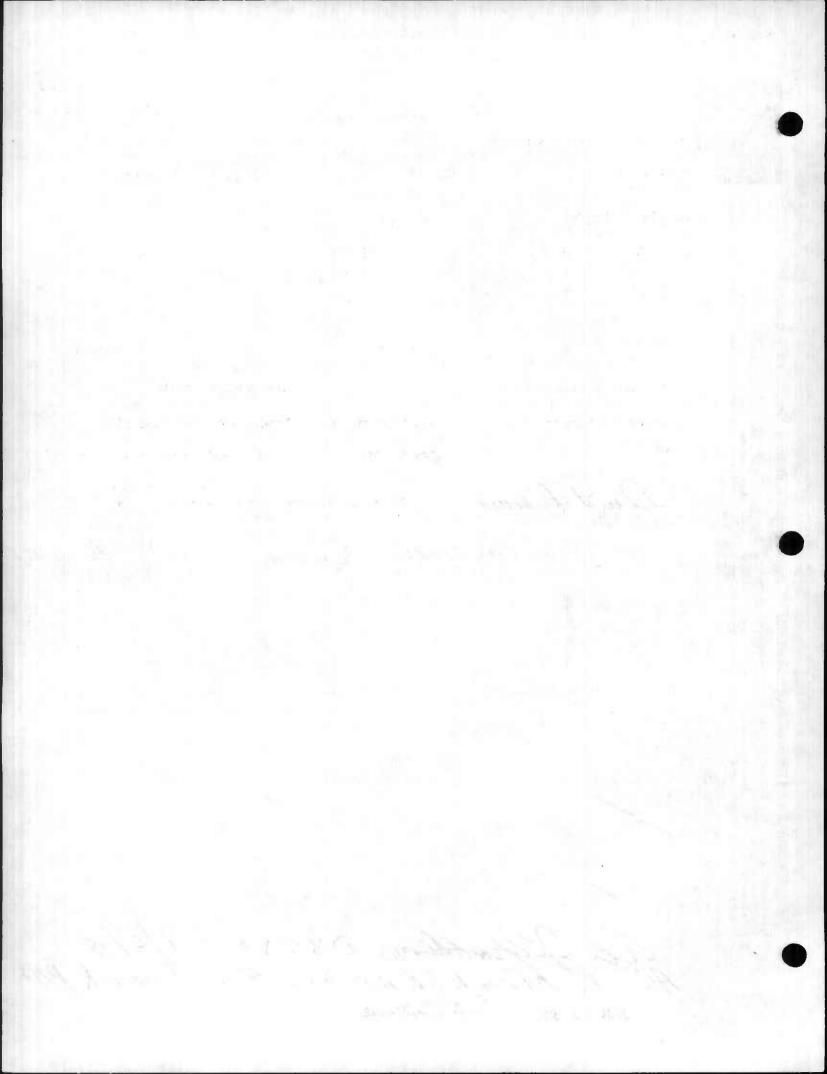
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/Medica	ıl .	MARIE S			7:30 p.								
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		Citizens Nursing				If I Index 1 Vee	Frederic			derick			
Funeral Director		5. Social Security Number 6. S 220-28-2738 Usual Residence of Decedent	M 2DF	e (In yrs. lest I	Yrs.	oy, Year) 2, 1904	9. Birthplec Country, Maryla	e (Stete or For					
ž ==	-	10e. State 10b. County		10c. City, To	own or Loc	ation				10d.	Inside City Lir		
49 5	0	Maryland Frederic	ck	Walk	ersvi	i 110			1 □ Yes				
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	John David Bidd:						Rebecca						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** Audrey D. Kelly 1998 2110 JANUARY /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Hospital Allegany Cumberland If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yee 8. Dete of Birth (Month, Day, Ye Sep 29, Birthplece (State or Foreign Country)
 PA **Funeral** Year) 1□ M 2X F Months Days 71 215-20-6103 Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Ves 2 No Director Cumberland Allegany 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1211 Bedford Street 21502 USA Funeral death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Bleck, White, etc. filed within 72 hours after ☐ Yes 2X No Yes, Give 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2X No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i. Peges 1 and 2 should be filed wi tment of Health end Mantal Hygien tant: if item 27 is marked other th ijury or other traumatic event, the Bd of Education 12 Retired Teacher Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lo Emmett A. Dougherty Iva M. (Donoughe) 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Bedford Street Cumberland MD 21502 John D. Kelly-husband Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete permit. Pege Department of Important: If any injury or SS Peter Paul Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 01/06 Cumberland MD 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Scarpelli Funeral Home, P.A. Cumberland MD 21502 Enter the diseese, or complications that or heart feilure. List only one cause on death. Do not enter the mode of dylng, such es cerdiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) the burial-trer P.O. Box 68760, physician Due to (or es e consequence of): for usa as attanding ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobacco use contribute to the cause of death? cete has been signed by , page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director. 25. Was cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Dinpatient 2 □ ER/Outpatient 3 □ DOA funerel 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Aftar 1 Natural 5 Pending investigation i or Attendin saftar death. I Director: Afi 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide Hospital To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end to of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8377 CLA DO 1998 **JANUARY** 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) her M.D. 924 SETON DRIVE CUMBERLAND, MD. 21502 VELANDIA, HRTEI.

DHMH 16 Rev 6/95

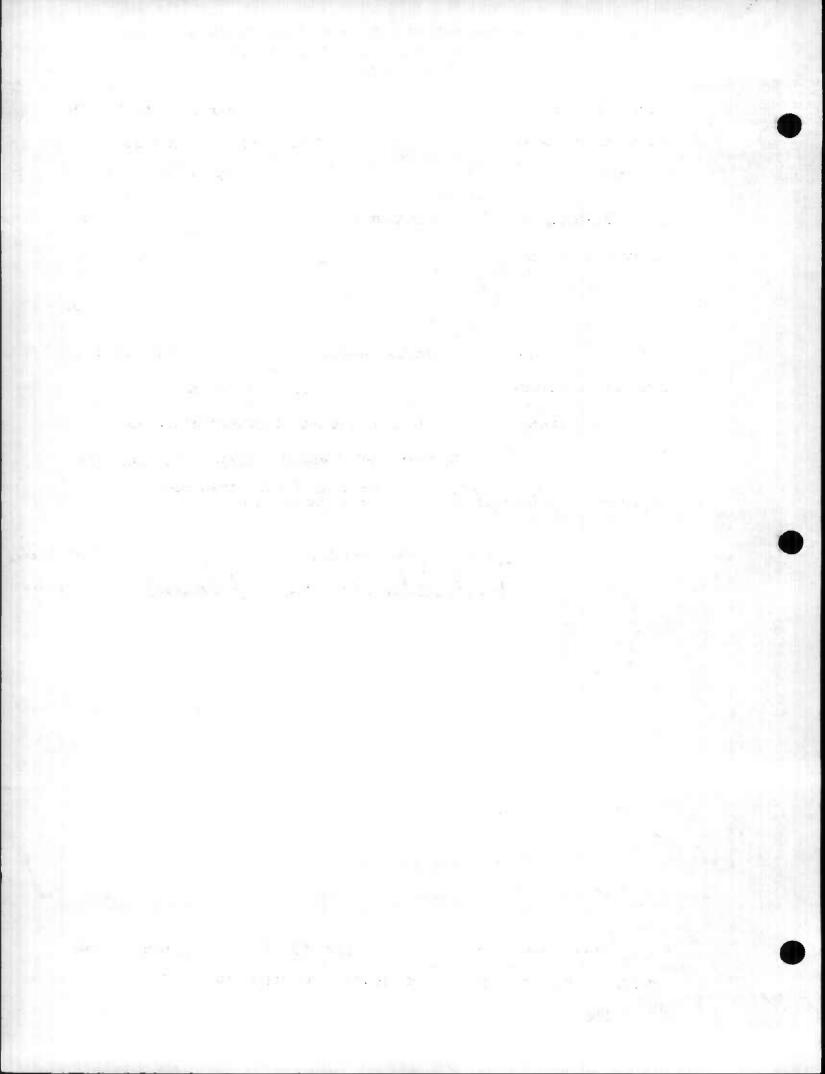
State

Registrar

31. Date filed (Month, Day, Year) JAN 0 6 1998

32. Registrer's Signeture

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120	Decedent's Nama (First, Middle, I	.ast)	Ce	rtificate of	Death	2. Dete of Dea	leg. No.	01	3. Tima of Deeth
Physician		KIDWELL				JANUARY		8 ^{Yeer}	1:55 AM
/Medical Examiner	4a. Fecility Neme (If not institution, g				4b. City, Town, or	Location of Daath	4c. County		1.00 1111
. Adminici	CUMBERLAND NURSI	NG HOME		3.00	CUMBERLA			GANY	
rai tor	5. Social Security Number 214-05-7426 Usuel Residence of Decedent	1 D M 0 D F	(In yrs. last birthday) 9 Yrs.	If Undar 1 Yaar Months Days			1918	9. Birthpla Countr	w. VA.
	10a. Stete 10b. County					10	d. Inside City Limits		
ctor	MARYLAND ALLEGA	NY	CUMBERLAI	ND					YYes 2□No
Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of V	Whet Countr	y?
ral	438 INDEPENDENCE			2150			U.S.A		
by Funeral	11. Meritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorcad	Armed Forcas?	1 ☐ Yes 2 ☑No If Yes, Give 1 ☐ Yes			Specify Yes or No- to Rican, atc.)		e - America ck, White, et .: WHI	tc.
Completed	15. Decadent's (Specify only highest g	Education rede com <i>pleted)</i>	dent's Usuel Occu kind of work done	pation during most of wo	rkina	16b. Kind of Bu	usiness/Indu	istry	
mpi	Elementary/Secondery (0-12)	College (1-4or 5-	-}				HOUGE	. REED	ED
	12 17. Fether's Name (First, Middle, Les	:t1	НО	USE KEEP	T	me (First, Middle,		KEEP	EK
To Be	SAMUEL LORETTA	•			MARY N		Maidell Salliell	(d)	
F	19a. Informent's Neme/Reletionship	(Type, Print)	19b. Mallir	ng Address (Stree	t end Number or R		r. City or Town.	Stete. Zin C	Code)
	OLIVER B. KIDWEI	L JR. HUS			ENCE STRE				
	20a. Mathod of Disposition		20b. Place of Dispo	sition (Nema of netory or other pla	ace)	Dete	20c. Location -	City or Tow	n, Stete
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec	☐Removel from State ify)	ROCKY GAP	,		6 1998	FLINTST	ONE M	ARYLAND
- Control	21. Signature of Funeral Service Lice	new A week	3	Name and Addr	ass of Eacility DAMS FUNE	TDAT HOME			
	1 tole 2	Mary			UR STREET			YT.AND	
10	23a. Part1. Enter the diseesa, or co- shock, or heart feilure. List only	nplications that caused	ha death. Do not ent	er tha mode of dy	ing, such es cerdia	c or respiretory err	est,	1	Approximate ntervel Between
a selection of the sele	Immediete Ceuse (Final disesse or condition resulting In death)	b	Due to (or es e consec		F				harters.
	Sequentielly list conditions, if eny, leading to immedieta cause. Enter Underlying Ceuse (Disease or Injury thet initiated events		ue to (or es e conseq	uenca of):					
Aedicai	Ceuse (Disease or Injury thet initiated events resulting In death) Last	c	ua to (or es e conseq	uence of):					
Med	resulting in death) Last	District in						į	
Physician/		d							
/sic	Part II. Other eignificant conditions	contributing to death but	not resulting in the un	nderlying ceusa gi	iven in Pert I.	23b. Did tobacco use contribute to the cau			he cause of death
						12(Y	es 2 No	3 Proba	bly 4 Unknow
Completed by						24a. Wes e	n eutopsy ned?	eveil	e eutopsy findings lebla prior to pletion of cause path?
E O						1 U Y	s 20 No	10	Yes 2□ No
Be	25. Wes case referred to medical				26. Plece of De	eth (Check only on			VI
To	examinar?	Hospitel: 1 Inpatien	t 2 ER/Outpatien	t 3 DOA Ot	her: 4 Nursing I	lome 5□ Reside	ence 8 Oth	er (Specify)	
	27. Manner of Deeth 1 Naturel 5 □ Pending	28e. Dete of Injury (Month, Dey	Year) 28b. Time of Injury	28c. Inju	ry at	28d. Describe he	w Injury occurr	ed	
cati	2 ☐ Accident Investigation			M 1	Yes 2 □ No				
Certification:	3 ☐ Suicide 6 ☐ Could not determined	building, etc.				28f. Location (Si City or Town	n, State)		
edicai	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of e end manner state	me, date end ptece opinion, deeth occu	e, end due to the coursed et the time, d	euse(s) end ma ate and placa, o	nner es stet end due to ti	ted. he ceuse(s)		
Me	29b. Signature and the of certifier	ond manner state		29c. Licen	se number	2	9d. Dete signed	(Month, De	ey, Year)
	· In da	ma-		D 33	280		Jan 6	199	18
	30. Name and address of person who	completed cause of dea	eth (Item 23e) (Tyne		-				
	DR SUNIL K. GUI		ENT AVE CU		MARYLANI	D 21502			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middla, Last) 2. Dete of Death 3 Time of Death Month ICHUATY 6 1/1 :30 PM Samuel (Nmi) LISTON 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington Hours Min. B. Date of Birth (Month, Dey, Year) Dec. 26, 1915 5. Sociel Security Number 6 Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplace (State or Foreign Country) West Virginia 100 M 2□ F Months Deys Yrs 82 236-03-2506 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 28 South Conococheague St. 21795 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yas 2 No If Yes, Give 1045 11. Marital Status 13. Was Decedent of Hispenic Origin? (Spacify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 1945 Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance Leather Processing 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) Jackson Leonard Liston Daisy May Cutright 19e. Informant's Neme/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 15 West Church St. Williamsport.MD 21795 Charles L. Brown III /Nephew 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Mem. Park Jan. 10, 1998 Williamsport, Maryland aral Serviced icense 22. Name and Address of Fecility 425 S.Conococheague St. Williamsport,MD 21795 Osborne Funeral Home 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errast, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediete Ceuse (Finel diseese or condition resulting in death) noute Dua to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of daeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

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Certification: To

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Tha law requires that the death certificate be executed

P.O. Box 68760,

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Physician

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r than "natural", or items 23s or 28s-f show the Madical Examinat result be notified at

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. Pagas 1 and 2 should be fill timent of Health and Mental Heant: If item 27 is marked oth jury or other traumatic even

permit. Page Department of Important: If any injury or once.

7 is marked other traumatic event,

filed within 72 hours after death with the Maryland

21215-0020

Baltimore. Maryland

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting In deeth) Lest

Pert II. Other eignificent conditions contributing to death but not resulting in the underlying causa given in Part I.

1 ☐ Yes 250 No 27. Manner of Death 1 Neturel 5 Pending

28b. Time of 28c. Injury at Work? 1 Yes

28e Place of Injury - At home, farm, street, factory office building, etc. (Specify)

28f. Location (Street and Number or Rurel Routa Number, City or Town, State)

29a, Certifier

2 Accident

3 Suicide

4 ☐ Homicide

**Certifying Phyalcian: To the bast of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifiar

29c. License number 100936 29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Day Year)

JAN 08

investigation 5 Could not be

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State Registrar Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** Month Yaeı Ethel Viola LAUFFER January 0250 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours 196-09-2241 Yrs. 93 Director Aug. 18,1904 Pennsylvania Usual Residence of Decadent 10e. State 10b. County r than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Washington NXYes 2 No Maryland Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 33 West Wilson Blvd. 21740 U.S.A. death Funeral Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Dacadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) within 72 hours efter 1 ☐ Yes 2 No 1 Navar Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white If Yes, Give Yeer or Dates: by 3 Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondery (0-12) 0-10 College (1-4or 5+) homemaker own home Peges 1 and 2 should be filed nent of Health and Mentel Hygint: If item 27 is marked other. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumeme) Be William В. Nora E. Swartzentruver 0 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 a Depertment of Health er Important: If Item 27 1s any injury or other trau Mrs. Jeanne Baker/Daughter 33 West Wilson Blvd., Hagerstown, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Jan 6, 1 ₺ Burial 2 Cremation 3 Removel from State Manor Cemetery Tilghmanton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1998 21. Signature of Euneral Service Licensee Minnich Funeral Home 22. Name end Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21470 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximeta interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leading to Immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest ettending physician end for use es the bunef-tran Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the P No 3 ☐ Probably 4 ☐ Unknown Records, þ 2 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy been completion of cause of deeth? cete hes l 1 🗆 Yes 21 No certificete Vital ial or Attending Physician: The offer death.

Signature of the contificet of the funeral director, page to by the funeral director, page to be the funeral director. Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes o ner of De 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Dete of Injury (Month, Dev Year) Division 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) To the Hospital or A within 24 hours efter To the Funaral Dirac completely filled in by 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical

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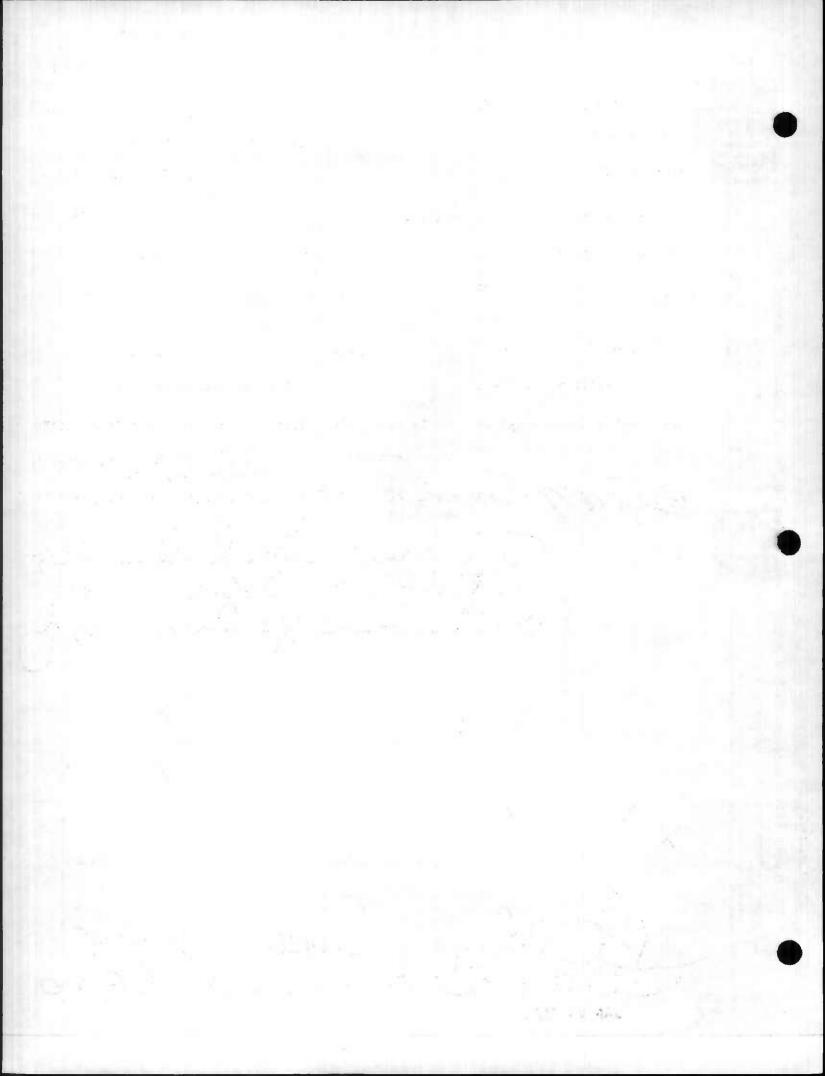
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4		FROSTBURG VILL							TBUR			LLEGANY	7	
Funeral Director		5. Sociel Security Number 6. S 217 14 4422 Usual Residence of Decedent	ex XDM 2□F	7. Age (In yrs	: last birthde Yrs	Months	Days	If Under Hours	Min.	8. Dete of B (Month, D OCT 7	ey, Year)	Co	hplece (Ste puntry) LAND	te or Foreig
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Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 7 Yes 2 If Yes, Give Yeer or Dat	es? □ No WW		3. Was Dece If Yes, spe 1 \(\text{Yes} \)	cify Cub	lispanic Ori en, Mexicar Specity:	n, Puerto	ecity Yes or N Rican, etc.)		4. Race - Ame Bleck, White Specify:		
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page 2	EO									10	Yes 2	No 1	I ☐ Yes 2	□ No
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E =	D: T	27. Manner of Deeth	28a. Date of	injury	28b. Time	of 2	8c. Injur	v at		28d. Describe			y)	
ctor: After	atio	1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigation		Dey Yeer)	Injury	М	Wor	Yes 2 ☐ i	No					
I Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)								28f. Location (Street end Number or Rural Route Number, City or Town, State)				
	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	reiclen: To the besi	s or examina	owledge, deation end/or	ath occurred Investigation,	et the tim in my o	ne, date en pinlon, deel	d plece, e	and due to the	ceuse(s) er date end p	nd menner es lace, end due	steted. to the ceus	e(s)
omp		29b. Signeture end title of certifier				290	. Licens	e number			29d. Dete	signed (Month	, Dey, Yeer)
> F 0		29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, I) 30. Name and address of person who completed date of death (Inon 23a) (Type, Print) SATURNINA CHANG M.D. Rt 36 FROSTBURG, JUAZA FROSTBURG 31 Date filed (Month Day York)												
5	-	30. Name end eddress of person who o	1		-								0/16	- 0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY 9, DOROTHY IRENE LOWERY 1998 6:15 pm 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Months Deys 1□ M 2Q F 213-22-4242 Yrs. 81 JULY 12, 1916 PENNSYLVANIA Usual Residenca ot Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ALLEGANY ELLERSLIE 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P. O. BOX 4 21529 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ M No It Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: WHITE 3℃Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) HENRY L. HOSSELRODE SARAH ANN WITT 19e. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JACK W. LOWERY/ SON P. O. BOX 88, ELLERSLIE, MD 21529 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20s. Method of Disposition 20c. Location - City or Town, State RESTLAWN MEMORIAL PARK JAN 13, XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LaVALE, MARYLAND 21502 5 Other (Specify) 1998 Funeral Service Lights 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL HOME 169 CLARENCE STREET, HYNDMAN, PA 15545-0636 loations that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, so cause on each line. Immediate Ceuse (Finel diseese or condition resulting in death) ANGESTIVE HEART HAILURE Due to (or es e consequence of): NAL MAILURE. M HEMODIALYSIS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EREBRAL INTARCTION

Physiclan /Medical **Examiner**

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I Director: A

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To the Hospital o within 24 hours eff to the Funeral Di completely filled in

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or Attanding Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

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Funeral

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r than "natural", or items 23a or 28a-f ahow the Mexical Examiner must be nothed at

Pages 1 end 2 should be filed within 72 hours effer death with in nent of Health end Mental Hygiene. http://or items 23a or in them 27 Is marked other then "natural", or items 23a or

7 is marked other traumatic event.

Department of Health er Important: If Item 27 is any injury or other trau

21215-0020

Baltimore, Maryland

the Meryland

Examiner Physician/Medicai P Completed

1XX Natural

3 ☐ Suicide

29a. Certifier

4 \ Homicide

(Check only

2 Accident

21. Signat

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 2 XNo 1 ☐ Yes 20 No

25. Wes case reterred to medical exeminer? 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Yes 2 ₹ No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth

28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how Injury occurred

**Xcertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Yeer) JANUARY 12, 1998

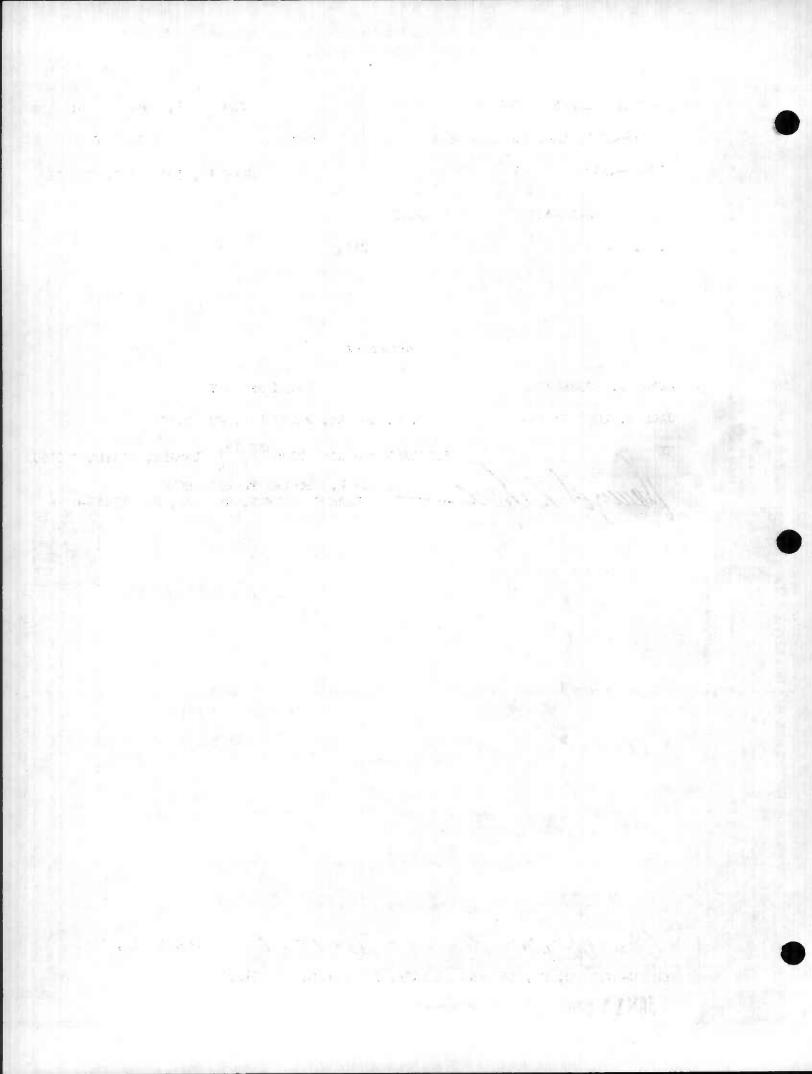
28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme and address of a me and address of femon who completed cause of deeth (Item 23e) (Type, Print)
CHANG-HYUN OH, MD, 48 TARN TERRACE, FROSTBURG, MD 21532

State Registrar



100)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item 19A, Dennis D., 1/15/98, drw Certificate of Death Reg. No: 1. Decadant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath **Physician** CECIL HAMILTON MARSHALL January 13, 1998 11:58 am /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day Year) May 21, 1919 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 M 2□ F 217-16-7804 78 Yrs. Director Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Locetion 28a-f show 10d. Insida City Limits Examiner must be notified at MD Anne Arundel Deale Director 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 461 Deale Road 20751 23a United States Funeral **Items** 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 72 hours after 1 M Yas 2 No 1943 If Yas, Giva Yaar or Datas: 1945 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ♥ No Spacify Specify: White þ 3 ♥ Widowad 4 Divorced 1945 d be filed within 72 hou antel Hygiena. ed other than "natura c event, the Medical E Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U. S. Government Statistician 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be permit. Pages 1 and 2 should be fi Department of Haalth end Mantel I Important: if Item 27 is marked ot any Injury or other traumstic even Robert Aplphonso Marshall Rodgers P. 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Dennis A. Marshall/son 5939 Brooks Woods Road, Lothian, MD 20711 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 M Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 1/16/98 Lothian, MD St. James Parish 21. Signatura of Funarat Sarvice Licensee 22. Nama and Addrass of Facility Rausch Funeral Home 7. Bell Gailes 8325 Mt. Harmony Lane, Mt. Harmony, MD 20736 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Physician /Medical Immadiate Causa (Final disaase or condition resulting in death) Examiner Examiner sician and burial-transit Saquantially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseasa or Injury that initiated avants rasulting in daath) Last physician s the burial Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ettanding p Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24 as an autopsy 24b. Wara autopsy findings aveilebla prior to complation of ceusa of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was cese refarred to medical exeminar?
1 ☐ Yas 2 → No Be 26. Pleca of Daath (Check only one) Hospitat: 1 Inpatiant 2 FR/Outpatlant 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To funeral 28a. Data of Injury (Month, Day Yaar) 27. Manger of Daath 28b. Time of 28c. Injury at Work? 28d. Dascriba how injury occurred After 1 Delaturel 2 Accident 5 Pending death. 1 ☐ Yas 2 ☐ No ofter death Director: A d in by the f Invastigation 6 Could not ba datarmined 3 ☐ Suicida 28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide • Funeral [To the Hospi within 24 hou To the Funer completely fil 29a, Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, and dua to the ceusa(s) and manner as stated. (Check only one) 2 Madical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and lime of certifier 29d. Data signed (Month, Day, Year) 4121

-1271

State Registrar 31. Data filed (Month, Day, Yaar)

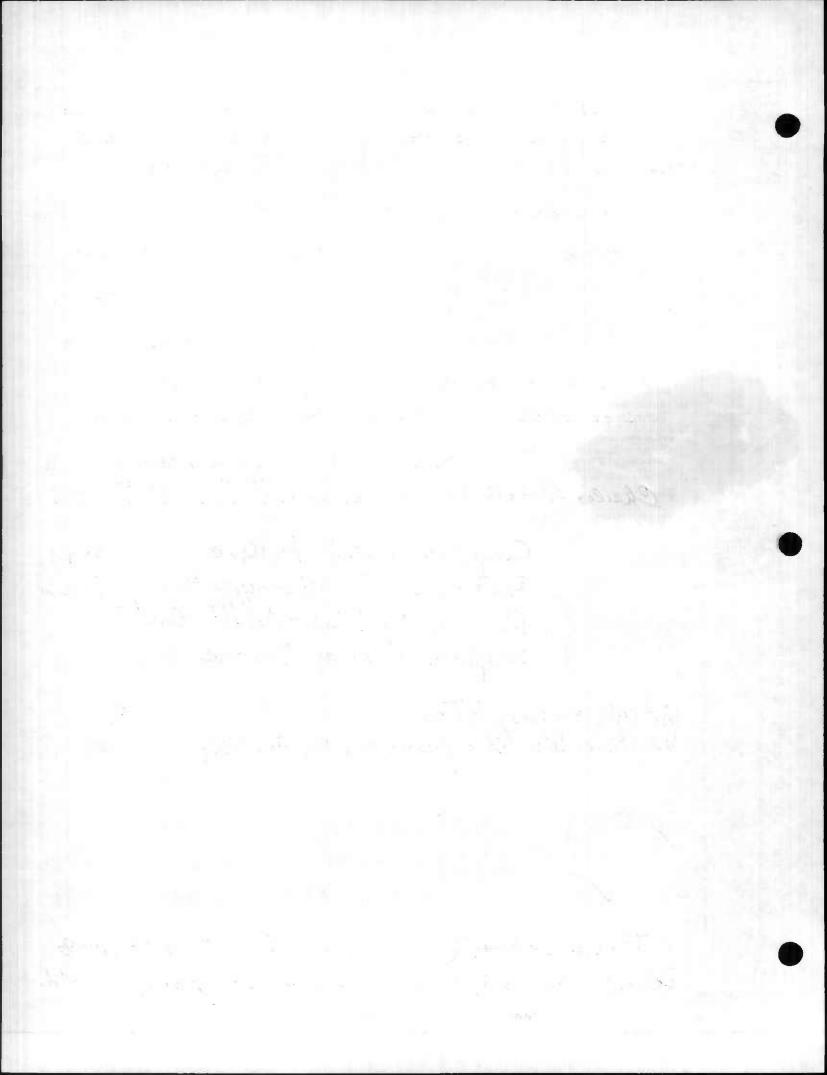
32. Registrar's Signatura

ema and eddress of parson who complated causa of deeth (Item 23a) (Typa, Print)

32. Registrar's Signatura

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204 W. St. Annapolis, Md.



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Physician

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Funeral

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/Medical

JULIA

5. Social Security Number

10a. Stata

MARYLAND

10e. Street and Number

064-52-6192

Usual Rasidance of Decedent

10b. County

traumatic event, the Medical Examiner must be notified at Completed tal Hygiene. Elementary/Secondary (0-12) HOMEMAKER 17. Fathar's Nama (First, Middla, Last) Be Pages 1 end 2 should be nent of Heelth end Mental it of Heelth end Mental DOMINIC PRINE MARIA ZACCARO 19a. Informent's Name/Ralationship (Type, Print) ROSE SEMINARA/DAUGHTER other 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, cramatory or other place) 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Spacify) MOUNTAIN VIEW CEMETERY 1/15/98 21. Signature of Funeral Sarvice Licensea 22. Nama and Addrass of Facility an Paul M. Dean BAST FUNERAL HOME 23a. Part 1. Entar tha disaasa, or complications that caused tha death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Henry Examiner Dua to (or as a consequanca of): Examiner irelio the death certificate be executed preumone Sequantially list conditions, if any, laading to immediata ceuse. Entar Undarlying Causa (Disaase or Injury that Initiated avents resulting in death) Last the buriel-tren Dua to (or as a consequence(of): 68760. ettending physician for use as the burle Physician/Medical Dua to (or as a consequence of): CUA Part II. Other significent conditions contributing to death but not rasulting in the underlying ceuse given in Part i. P.0. the ate hes been signed by pege 2 should be detect The lew requires that Records, þ Be Completed this certificate Division of Vital Attending Physician: 25. Was cese refarred to madical axaminar? 1 Yas 2 No P 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA funeral Certification: 27. Manner of Death 28c. injury at Work? 28a. Data of injury (Month, Dey Year) 28b. Tima of After 1 ■ Naturel 2 □ Accidant 5 Pending Invastigation death. 1 ☐ Yas 2 ☐ No eral Director: A filled in by the fr 3 Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) or A efter 4 Homicide Hospital C within 24 hours Medical 29a. Cartifiar (Check only one) 29b. Signatura and title of certifian 29c. License number D3251

32. Ragistrar's Signatura

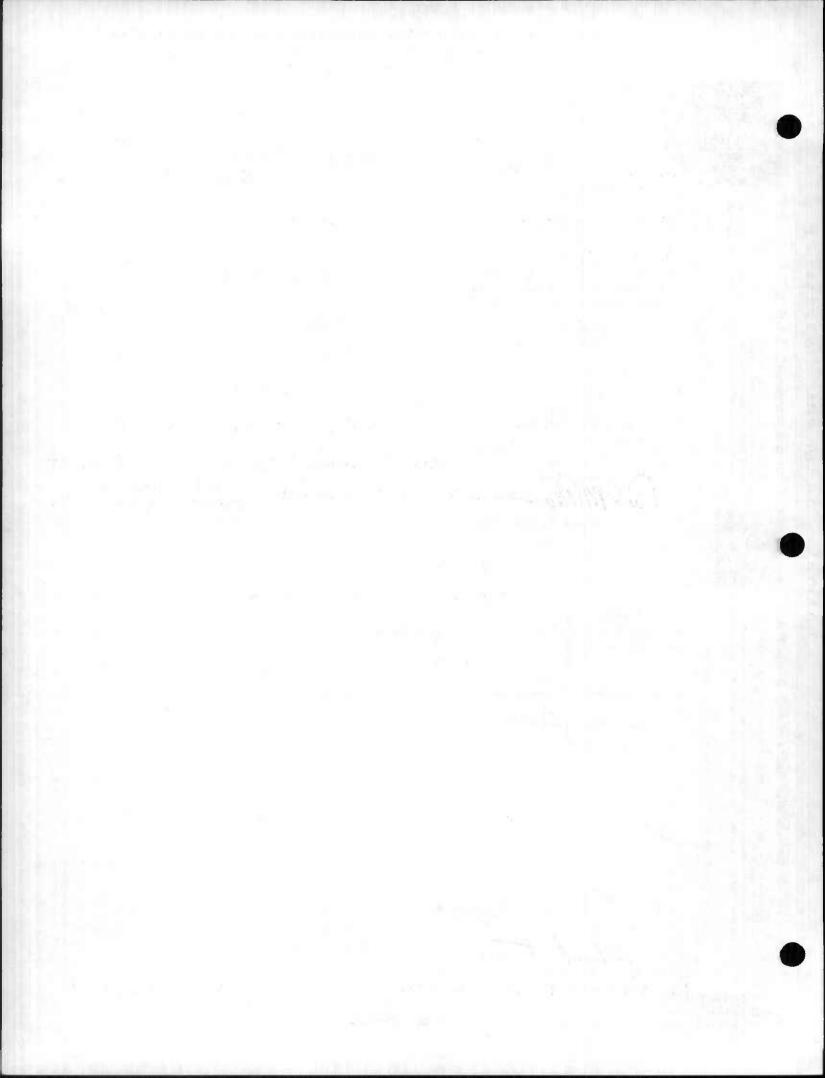
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaa (NMN) MARINELLI 910 January 1998 12 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death / 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Undar 1 Yaar | if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) APRIL 5, 1899 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1□ M 2X F Days Yrs. 98 NEW YORK 10c. City, Town or Location 10d. Insida City Limits 1XX Yas 2 □ No WASHINGTON SHARPSBURG 10f. Zip Coda 10g. Citizan of What Country? 137 EAST MAIN STREET 21782 U.S.A. 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify 3 Nidowed 4 Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry College (1-4or 5+) OWN HOME 18. Mothar's Nama (First, Middla, Maidan Sumama) 19b. Malling Addrass (Straat and Number or Rurel Routa Number, City or Town, State, Zip Code) P.O. BOX 277, SHARPSBURG, MARYLAND 20c. Locetion - City or Town, Stata SHARPSBURG, MARYLAND 7606 Old National Pike Boonsboro, Maryland 21713 Approximata Intarval Between Onsat and Death 23b. Did tobacco use contribute to the causa of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformad? complation of ceusa of death? 2/2 No 1 Tas 1 ☐ Yas 2 ☐ No 26. Piaca of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 28d. Dascribe how injury occurred 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) to Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29d. Dete signed (Month, Dey, Yeer) MD 30. Nama and address of person who completed ceusa of daath (Item 23e) (Type, Print) Keedysville Marylan Guedenet 100 Lane recting

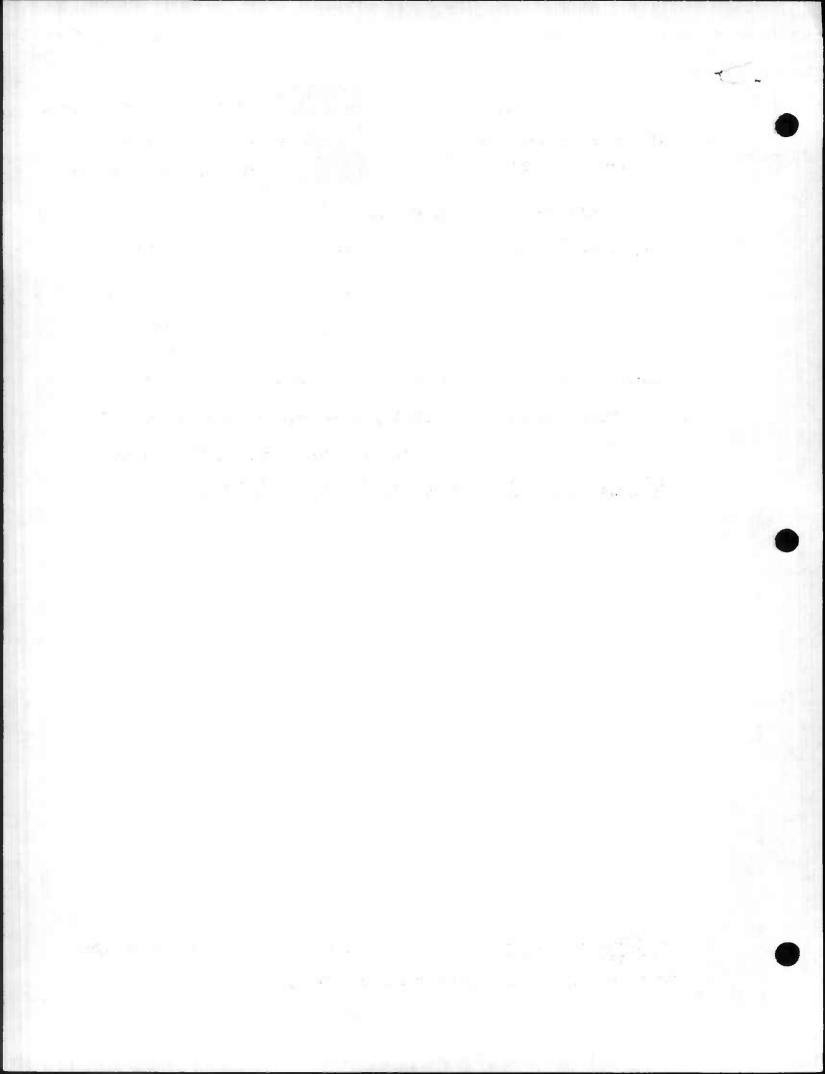
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** STELLA ALLEN MCLYMOND 1998 JANUARY 8:55 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, May 29, 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1□M XX F Months Deys Hours Year) 1898 115-32-7017 99 Yrs. Director Usual Rasidenca of Decedent death with the Marylend 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits na 23a or 28a-f short MD Washington Williamsport 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 154 N. Artizan Street 21795 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 M Yo If Yes, Give Yaar or Datas: r than "natural", or items the Medical Exerciner ma Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indien. filed within 72 hours efter 1K Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas X No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Teacher Public schools . Pages 1 and 2 should be filed w tment of Health end Mental Hygier tant: if item 27 is marked other th jury or other traumatic event, to 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Loretus McLymond LaPear1 Allen 2 19a. Informant's Neme/Raietlonship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Urlla L. McLymond/Sister 154 N. Artizan St., Williamsport, MD 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremation 3 ☐ Removel from Steta Department of important: If any injury or Hagerstown Crematory Jan. 10. 1998 Hagerstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funerei Servica Licansas 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. M00522 306 Union St., Berkeley Springs, WV 25411 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata ervel Between Onset end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) ASPIRATION PNEUMONIA 3 DAYS Examiner Due to (or es e consaguenca of): Examiner DYSPHAGIA 12 DAYS buriel-transit The law requires that the death certificete be executed Sequantielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): pue Box 68760, physiclen CEREBRAL INFARCT 12 DAYS Physician/Medical the Dua to (or as a consequence of): 98 for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yes 2(T)No Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? paga 2 certificate 1 Yes 2 No or Attending Physician: director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: XX Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 X Natural 5 Pending 1 ☐ Yas 2 ☐ No deeth. Investigation 2 Accident 24 hours efter deet Funeral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide Hospitai 29a. Certifiar Medicai XCertifying Phyalclan: To the bast of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and piece, end due to the cause(s) end menner stated. within 2 29b. Signature and July of certifier 29c. License number 29d. Data signed (Month, Day, Year) D33700 JANUARY 9, 1998 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) TED E. HOWE, MD 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State JAN 1 2 1998 ha Davidson-Randoll Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Month Hazel NMN MULLENAX 758 Has 4a. Fecility Neme (If not institution, give straet end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Homewood Nursing Home Williamsport Washington If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Sept.5,1912 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days Hours 1□ M 2⊠ F Yre 232-02-1219 85 Virginia Usuel Residence of Decedant 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits W. Va. Pocahontas 1 ☐ Yes 2 ☐ No Bartow 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? P. O. Box 185 24920 USA 12. Was Decedent Ever In U,S. Armed Forcas? 14. Race - American Indien, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married 1 Yas 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) her own home housewife 4 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Arthur W. Mullenax Harriet Sponaugle 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen Cook - daughter 13732 Greencastle Pike, Hagerstown, Md. 21740 20b. Piece of Disposition (Neme of cematary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ₺ Buriel 2 □ Cremation 3 □ Removal from Stata Blue Grass, Virginia 1-11-98 Mullenax Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furiera Service Lice 2. Nama and Address of Fecility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or respiretory arrast, shock, or heer feilure. List only one ceuse on each line. Approximate intervei Between Onset and Death Immediate Ceuse (Final disaesa or condition rasulting in deeth) NUTHETRUM Due to (or es a consaguança of)

Physician /Medical Examiner

ettending physician and for use es the burial-transit

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after death Director:

24 hours

To the Hosp within 24 hor To the Fune completely fi

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Physician

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remember over than "natural", or items 23s or 28s-f short raumstic event, the Mexical Examiner must be notified at

e filed within 7: el Hygiene.

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other

injury or

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Examine

Physician/Medical

P

Be

To

Certification:

Medical

Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown

24a. Was an autopsy performed?

24b. Wera eutopsy findings aveilabla prior to completion of cause of deeth?

1 Tas

1 ☐ Yas 2 ☐ No

25. Wes cese referred to medical axaminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

27. Menner of Deeth 1 Weturel

31. Data filed (Month, Dey, Year)

28e. Date of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

28c. Injury et Work? 1 Yas 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29b. Signatura and Hours 29c. License number

MECTA

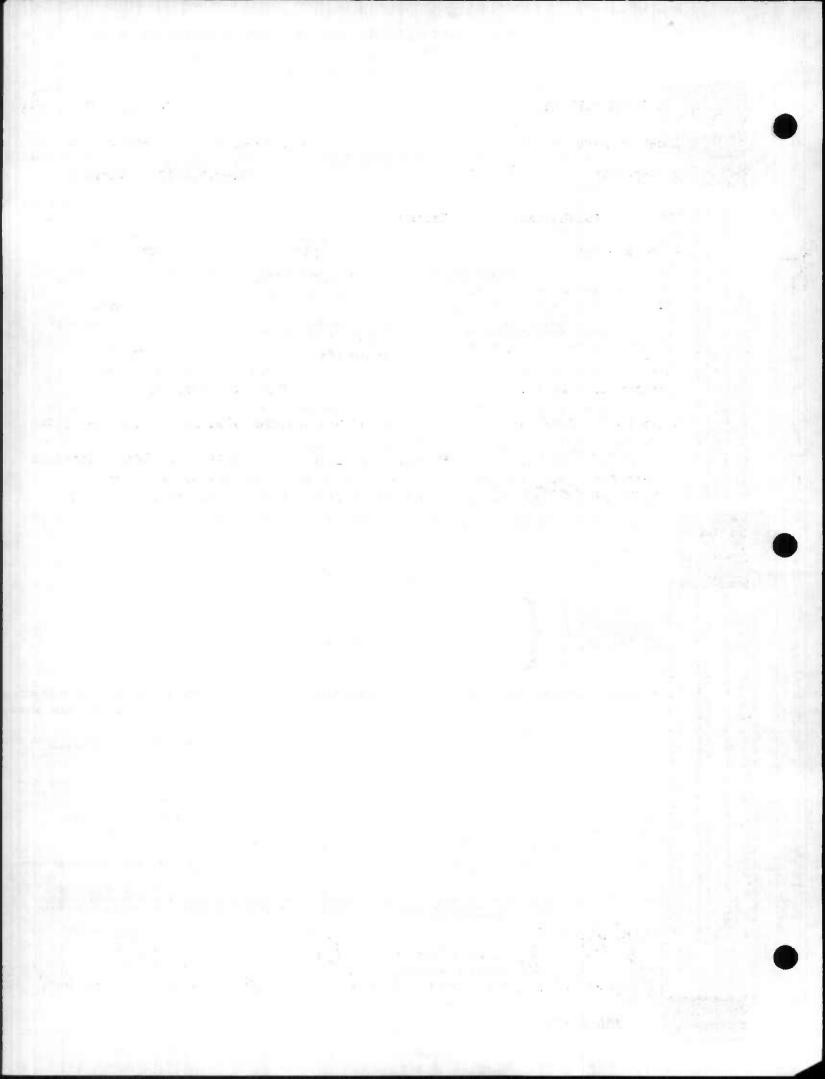
29d. Date signed (Month, Day, Year)

cause of deeth (Item 23e) (Type, Print) uni

Registrar

JAN 0.9 1998

32. Registrar's Signature chia Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Tima of Daath Month **Physician** PAUL ROBERT MIJANOVICH 1105 JANUARY /Medical 4e. Fecility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death-Examiner 4c. County of Death Washington County Hospital Hagerstown Washington 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth (Months Days Hours Min. June 9, 1925 5. Social Security Number 9. Birthplace (State or Foreign Country)
Hagerstown, MD **Funeral** MM 2DF 219-14-9237 Director Usuat Rasidanca of Dacedant 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits Director Yas 2 No Washingtown Hagerstown r than "natural", or items 23e or 28e-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1130 Hamilton Boulevard 21742 USA 12. Was Dacadant Ever In U,S. Armed Forces? Wayes 2 No 1943- Was Dacadant of Hispanto Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Spacify: Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 1945 Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacadent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Yard Master Railroad 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental Nicholas Mijanovich Clara Virginia Faver 19a. Informant's Name/Ratationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) Department of Health as Important: If Item 27 is any injury or other trau Kenneth P. Mijanovich, Son 920 Hamilton Blvd., Hagerstown, Maryland 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Smithsburg Crematory Jan. 5 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specity) 22. Nama end Addrass of Facility
Douglas A. Fiery Funeral Home 21. Signeture of Funerat Sarvice-bicanses Rlli founke 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Pert1. Entar the chase, or complications thet caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or hear the res. List only one cause on each line. Approximata Interval Batwaan Onsat end Daath **Physician** /Medicai Immediate Causa (Final ALUGENT **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that the death cartificata be executed burial-transi Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): that initiated events rasulting in death) Last tha Dua to (or as a consequence of) d for usa as the P.O. Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANDVI Division of Vital Records. þ Completed 24a. Was an autopsy performed? 24b. Ware autopsy findings avaitable prior to completion of causa of death? page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa referred to madical axaminar? 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No ert this To the Hospital or Attending Privy within 24 hours after death.

To the Funeral Director: After thi funaral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred 5 Panding Investigation 1 Naturat complately filled in by the f 2 P Accident 6 Could not be datermined 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To the bast of my knowledga, daath occurred at tha time, data end placa, and dua to tha causa(s) end mennar es stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the causa(s) end mannar stated. Medical (Check only 29b. Signature and titla of certifiar 29c. Licensa numbar 29d. Date signad (Month, Day, Yeer) 1602A 30. Nema and address of person who complated cause of daath (Item 23a) (Type, Print)

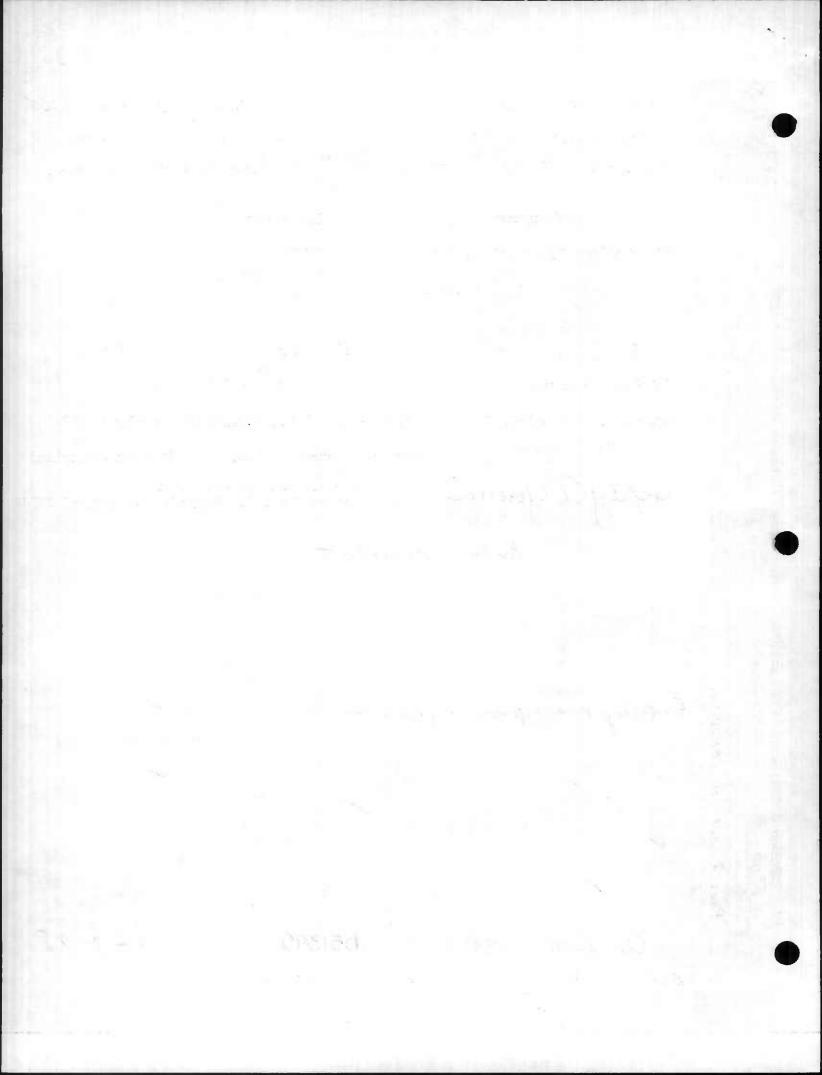
State Registrar 31. Dete fited (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 8 0 | 560

					Certific	ate of	Death		Reg. No.		
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Physici /Medi		ETHAN ALD	ENE MID	DLEKAU	FF			JANU	ANDAY 1	998 C	2235
Examir		4a. Fecility Nama (If not institution, gir	va straat and numbar)				4b. City, Town, or	Location of Dee	th 4c. County	of Death	
		Washington Co	,	pital			Hagers			shingto	วก
Funeral Director		5. Sociel Security Number 6. 214-09-1742 Usual Rasidanca of Dacedent	Sex 7. Ag 1 □ M 2 □ F	e (In yrs. last bir 82	thday) If Un Yrs. Month	der 1 Year ns Days			rth a <i>y, Year)</i> r 21,191	9. Birthplaca Country) 15 Mar	(State or Foraig y land
dand w		10a. Stata 10b. County		10c. City, Tow	n or Location					10d. In	sida City Llmit
Many First	to	Maryland Washi	ington	Hage	rstow	n				1)	Yas 2 N
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deat	Funeral	11. Marital Status	12. Wes Dacedant	Evar in U,S.	13. Was De	cedent of h	Hispanic Origin? (an, Mexican, Pua	Spacify Yes or N		ace - Amarican Indien,	
within 72 hours efter death with the Maryland ene. than "natural", or Neme 23a or 28a-1 show he Wedcel Exemine must be pullified at	by	1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowad 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2Â☐ If Yas, Giva Yaar or Datas:			2 X No		no Hican, atc.)	Specif	ck, Whita, atc. by: Whit	е
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ges 1 and 2 should be filed within 72 hd to Health end Mental Hygiene. If Item 27 is marked other than "nature or other traumatic event, the Medical	Completed	Elamantary/Secondary (0-12)	Collaga (1-4or	5+)			during most of we		g		
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s 1 and 2 of Health Item 27 i		Ruth C. Midd:	Lekauff		Richmo Disposition (/		treet, H				
Pa ner nnt:		20a. Mathod of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Othar (Special		com a fa	sburg (r other pla remat	torium O		Smiths	ourg, Ma	
permit. Pag Depertment Important: If any Injury o		21. Signatura of Funaral Sarvica Lica	rady		Andre	and Addra	nss of Facility Coffman ntietam	Funeral	Home,	Inc.	21740
		23a. Part1. Entar the diseesa, or com shock, or heart failure. List only	plicetions that cause	tha daath. Do r						Appr	oximeta
Physician /Medical Examiner		Immediata Ceusa (Final disassa or condition resulting in daath)			onoil	K	1 WEDNET	,		Onse	Wal Betwean at and Death HRS
eath certificate be executed ettending physicien and for use as the buriel-trensit	Medical Examiner	Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last	b	Dua to (or as a c		of):	PUEMS			U/	AKNOWA
th certendir	an/M		d								·
the et hed fo	sicl	Part II. Other significant conditions of	contributing to death b	ut not resulting Ir	the undarlyin	g causa giv	van in Part I.	23b. Dld	tobacco use co	ntributa to the	cause of deat
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aw requir	Completed								an autopsy ormed?	24b. Wara au evellable complati of daath	prior to
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lcian: The certificate rector, pag	Be	25. Was case rafarred to madical axaminar?					26. Place of Da	ath (Chack only	ona)		
O O	To	1 Yas 20 No	Hospital: 1 Inpatia	int 2□ER/Ou	tpatient 3	DOA Oth	nar: 4 Nursing	Homa 5□Ras	idence 8 Oth	nar (Specify)	
ding Ph h. After thi funeral	:uc	27. Mannar of Daath Natural 5 □ Panding	28a. Data of Inju (Month, Da		ima of	28c. Injur Wor	y at	28d. Dascribe	how Injury occur	red	
or Attending efter death. Director: After 3 in by the fune	Certification:	2 Accident investigatio 3 Suicida 6 Could not be datarminad	ding (Month, Day Yaar) Injury Work? stigation M 1 □ Yas 2 □ No					28f. Location (Straet and Number or Rural Routa Number City or Town, State)			
Hospital or 24 hours efte Funeral Dir tely filled in	edical C	29a. Cartifiar 1 Certifying Ph (Check only one)	nysician: To the best ninar: On the basis of end manner st	axamination and	, daath occurre d/or invastigati	ed at the tir on, in my o	ma, data and plac opinion, daath occ	e, and due to the urrad at tha tima	causa(s) and madata and placa,	annar as stated. and dua to tha c	ausa(s)
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ro the Hu vithin 24 ro the Fu	Med	29b. Signeture end title of certifiar			1	29c. Licans	a number		29d. Date signe	d (Month, Day, 1	Yaar)
To the Mospital or Attend within 24 hours efter deat To the Funeral Director: completely filled in by the	Med		Jus ac	2	D	-40/	sa number		29d. Date signe	d (Month, Day, 1	Yaar)

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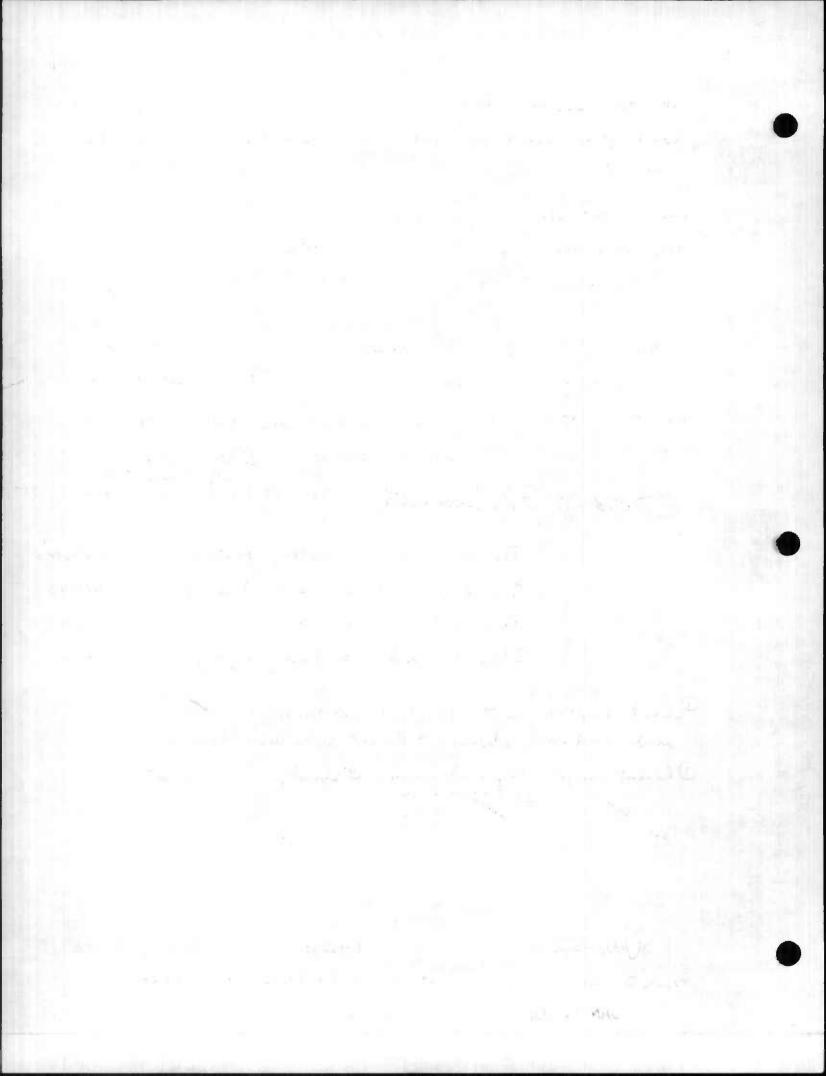
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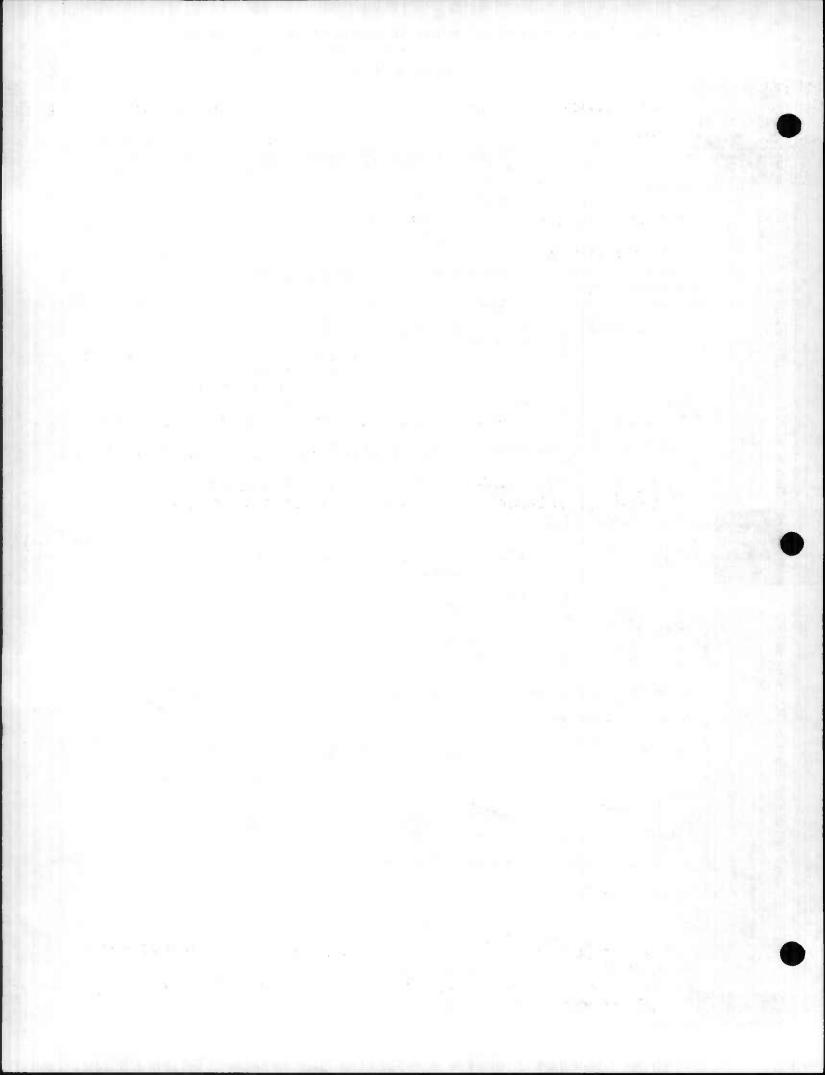
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_	hysicia /Medic	_	1. Decedent's Name			nartic	^				2. Dete of De Month	eeth Dey	Yeer / 998	3. Time of Deet
	xamin		4e. Fecility Name (III			hespil	-21		4b. City, To	wn, or Lo	ocation of Deal	th 4c. Cou	shing'	ton
	neral ector		5. Sociel Security N 213-18-98	394	ex 7. □ M 2	Age (In yrs. la 75		If Under 1 Yea Months Deys		24 Hrs. Min.	8. Dete of Bi (Month, P June 1	z, 1922	9. Birthi Cou	olece (State or Fore dry) land
with the Maryland	utities at	ctor	Usual Residence of 10a. State Maryland	Decedent 10b. County Washing	ton		Town or Lo							10d. Inside City Lim
th with th	at be no	al Directo	17435 Ga					10f. Zip Code	21740)		10g. Citizen d	of Whet Cou	ntry?
020 urs after death	E Diagram	by Funeral	11. Maritei Status1 ☐ Never Marrie3 ☐ Widowed	ed 2 A Married	12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Date	es? 🖾 No		Was Decedent of f Yes, specify Cui 1 ☐ Yes 2 ☒ No			ecify Yes or No Rican, etc.)	0- 14. F 8	lace - Americ leck, White, cify: W	
and 21215-0020 be filed within 72 hours after tal Hygiena.	the Medical	Completed	(Special Special Speci	15. Decedent's Entity only highest greater (0-12)	ducetion de completed) College (1-4	or 5+)		dent's Usuel Occu kind of work done DO NOT use retire emaker	upetion e during mos ed)	t of work	ing		Business/In	
Maryland of 2 should be filed the and Mental Hyg	tic event,	To Be C	17. Fether's Name ((First, Middle, Last, Raymond		Jacobs			18. Mothe		e (First, Middle Frances			ner
Mary and 2 should be alith and N	r traumet		19e. Informent's Na Mr. Glenn			band		ng Address (Street						21740
Baltimore, Maryland 212 permit. Pages 1 end 2 should be filled within Department of Health and Mental Hygiena. Immortant: It fleat 27 is marked other than	any injury or oth			Cremation 3 5 Other (Specif	y)	ate C6	metery, crer t Hav	sition (Name of netory or other pl en Cemet	ery		Dete Jan. 5,1998 innich		stown,	Marylan
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cords, P.O. Box 68760, requires that the death certificate be assecuted approximately the attending physician and	es the bur	Medical Examiner	Sequentially list cor if eny, leading to im ceuse. Enter Under Ceuse (Disease or i thet Initiated events resulting in deeth) L	nditions, imediate rlying injury	o. Pers	isten	es e consec	Troxer	nia	4	u (oro	na		weeks weeks years
O. Box	for us	cian	Pert II. Other elgnifi	icant conditions c				nderlying cause g	iven in Part I	9	23b. Dld	tobacco use	contribute to	o the cause of de
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Division tal or Attending rs after death.	led in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of building,	Injury - At hor, etc. (Specify)	ne, farm, str	eet, factory, office				(Street end Nu wn, Stete)	mber or Run	al Route Number,
the Hospi hin 24 hou	nplataly fil	edic	one)	1 Certifying Ph 2 Medical Exen	ysicien: To the be niner: On the basis end menner	s of examination	ledge, deeth on end/or inv	estigation, In my	opinion, dee	d place, th occurr	end due to the ed et the time,	, dete end plac	e, and due to	o the ceuse(s)
D Sig C	00		29b. Signeture end t	title of certifier	mp			29c. Licen	081			Januar		
			30. Name end eddre	ess of person who	completed cause of	of deeth (Item	23e) (Type,	Print)	erstou	~~	MD	2174	J	



State of Maryland / Department of Health and Mental Hygiene

Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Dey MARY ELIZABETH MARKWOOD **JANUARY 4,1998** /Medical 5:38 PM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, SEPT 8) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) MARYLAND **Funeral** 1□M 2√2 F 214-05-6144 87 Vrs Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at Director MARYLAND ALLEGANY 1 Yes 2 No CUMBERLAND the 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 6 801 COLUMBIA AVENUE 238 21502 U.S.A. Pegas 1 and 2 should be filed within 72 hours effer death nent of Heelth end Mental Hygiena.
Int: If item 27 is marked other than "natural", or Itema 23 ary or other traumatic event, the Medical Examinal mains. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11 Marital Status 14. Race - American Indien Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify: WHITE þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 HOUSE KEEPER HOUSE KEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be GEORGE RANK 2 MAMIE HOENICKA 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) VANCE MARKWOOD HUSBAND 801 COLUMBIA AVE. CUMBERLAND MARYLAND Baltimore, 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Date ST LUKES CEMETERY JAN 7 1998 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Pega Depertment of Important: If any Injury or once. CUMBERLAND MARYLAND 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Approximal /Medical Immediate Ceuse (Finei diseese or condition resulting in deeth) Metastatic carainoma rectal Examiner Due to (or es e consequence of): Examiner The law requires that the death certificets be executed burial-transi Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest pue Due to (or es e consequence of) Box 68760. ettanding physician for use as the buria Physician/Medical Due to (or es a consequence of) Pert II. Other eignificant conditione contributing to death but not resulting in the underlying ceuse given in Pert I. ate has been signed by the page 2 should be detached Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 20 No 3 Probably 4 Unknown myocardial infarction by Completed 24b. Were eutopsy findings 24e. Wes en eutopsy Cerebro vasenlar eveileble prior to completion of ceuse of death? sceident (12) cereb-al homisphere performed? certificate has 1 ☐ Yes 2 1000 Malnutrition 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 1 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funerel 27. Menner of Death 28c. Injury et Work? Certification: 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturel deeth. 1 Yes 2 No 2 Accident within 24 hours after deet To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piace, end due to the ceuse(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) **JANUARY 4,1998** 3 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Wast Dr. Cumberland, Med 21502 Mis Bishop ALBERT 925 CMU Z Arwsa 32. Registrar's Signature State Registrar



Amended #17, nds, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1/12/98, Allegany County State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Jan 5 1998 **Physician** 10:34AM Rosalie Elizabeth Misch /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Cumber land **Allegany** Sacred Heart Hospital If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) June 5, 1919 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year 9. Birthplece (State or Foreign Country) **Funeral** Deys Months Hours Min 1 □ M 2X F Yrs. 78 MD Director 214-07-3506 Usual Residence of Decedent Manyland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours aftar daath with the Maryla nant of Health end Mental Hygiane.
If it fem 27 is marked other than "natural", or items 23a or 28a-f shown in the property or other transities of the property in Madicial Examinations to profited in Madicial Examinations to profited in the pro Director 1 Yes 2X No Cresaptown MD Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. BOX 5021 CONNECTICUT AVE. USA 21502 Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Married 2 Married Yes 2X No f Yes, Give Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify by 3 € Widowed 4 Divorced Year or Dates: white Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Retired 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Shelley Lottie (Chilcott) P 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 14812 Lone Oak Road Cresaptown MD 21502 Eleanor Wolford-niece Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pagas Department of Himportant: if its eny Injury or ot once. 1 ☐ Buriel 2 【Cremation 3 ☐ Removel from State umberland Crematory Cumberland MD 4 ☐ Donetion 5 ☐ Other (Specify) 01/06 22. Name and Address of Fecility
Scarpelli Funeral Home, P.A. 21. Signature of Funerel Servica Licansee Cumberland MD 21502 23a. Pent Enter the disease, or complications that daused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical e Arteriosclerotic cardiovascular heart disease uk yrs Examiner Hyperlipidemia uk yrs Physician/Medical Examiner tha burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, physiclan The law requires that the death cartificate be Due to (or es e consequença of) use est ò ed by tha a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No COPD, obesity signed t Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? diractor, page 2 should Completed 24a. Wes en eutopsy performed? peen hes cartificeta 1 Yes of Vital or Attending Physician: 25. Wes case referred to medical examiner?

12 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpetient 3□ DOA Certification: To this the funarel 27. Menner of Deeth

1 Naturel

2 □ Accident Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Aftar t Division 5 Pending investigation 1 ☐ Yes 2 No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A 6 Could not be determined 3 Suicide in by t 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

Deficial Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of pertiller 29d, Date signed (Month, Dey, Year) 29c. License number Jan 5 1998 Dpty Med EX D 09157 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

124 w 3rd st Cumb MD 21502

32. Registrar's Signature

Registrar

State

Paul Snow,

M.D.

Note that the state of the stat

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 564 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1998 Jan 4, 5:55 pm Lena G. Meadows 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frostburg Frostburg Village Nursing Home Allegany 5. Sociel Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) WV 1 M 2√2 F Months Deys Hours Min Yrs. 215-20-6782 Mar 3, 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1- Yes 2 □ No Cumberland Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 220 Somerville Avenue USA 21502 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11 Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nursing Home Ret. Nursing Asst. 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) W.W. Townsend Katie (Reid) 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 814 Ashland Avenue Cumberland MD 21502 Marjorie Cunningham-daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Cedar Lawn Cemetery 01/07 Hagerstown MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Penf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) 10 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of) Pert It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 1 Inpatient 2 ER/Outpatient 3 DOA

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To the Hospital within 24 hours e Hospital

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Physician

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Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

Examiner Physician/Medical ð Completed diractor, Be Certification: To funaral filled in by the

Medicai

27. Menner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide

29a. Certifier

5 Pending Investigation 6 Could not be

28e. Dete of Injury (Month, Dey Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 TYes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Madicet Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

28d. Describe how injury occurred

29b. Signeture end title of certifier

D 12532

29c. License number

Cumberland MD 21502

29d. Date signed (Month, Dey, Year) 9

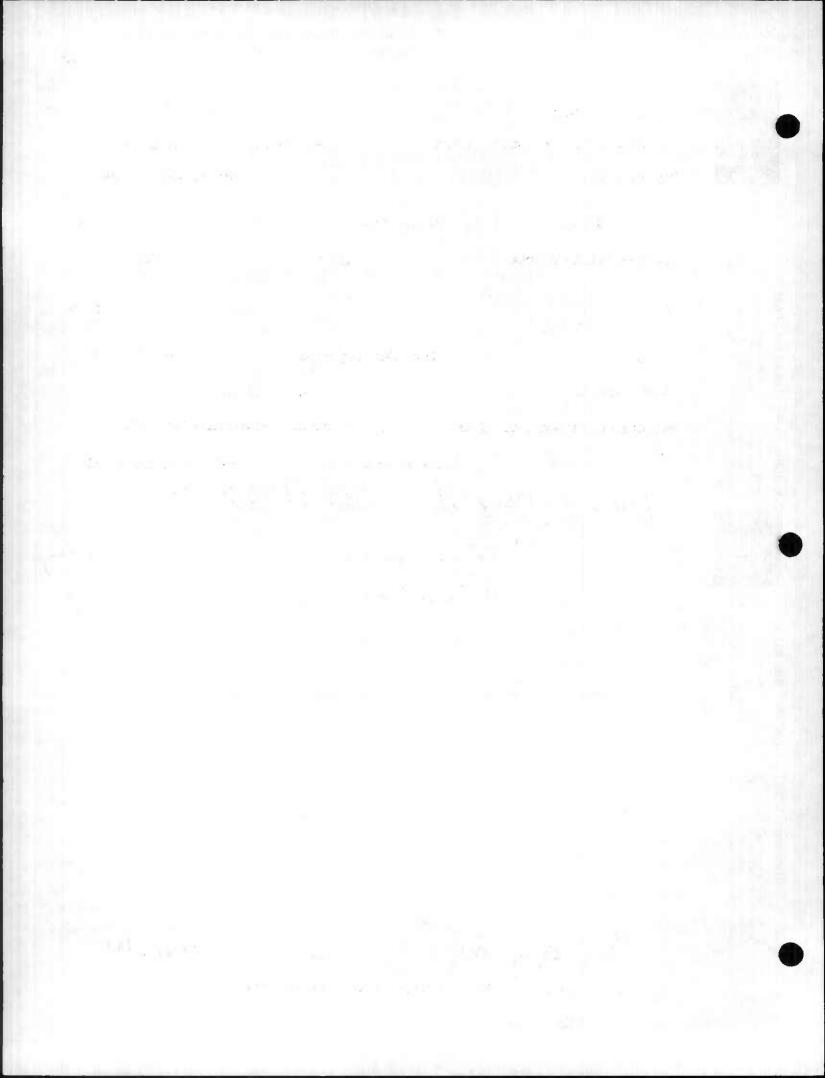
State Registrar

Dr. George Breza 31. Dete filed (Month, Day, Yeer)

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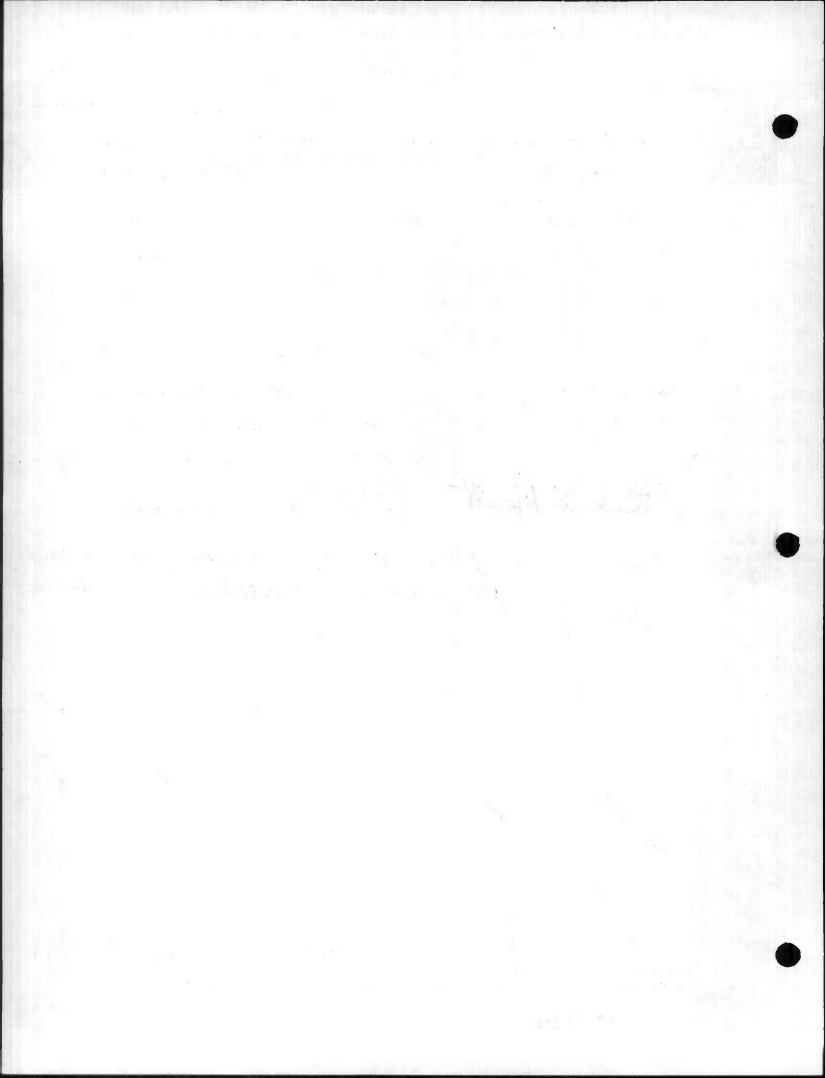
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32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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rland		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. inside City Lim
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29d. Date signed (Month, Dey, Year)

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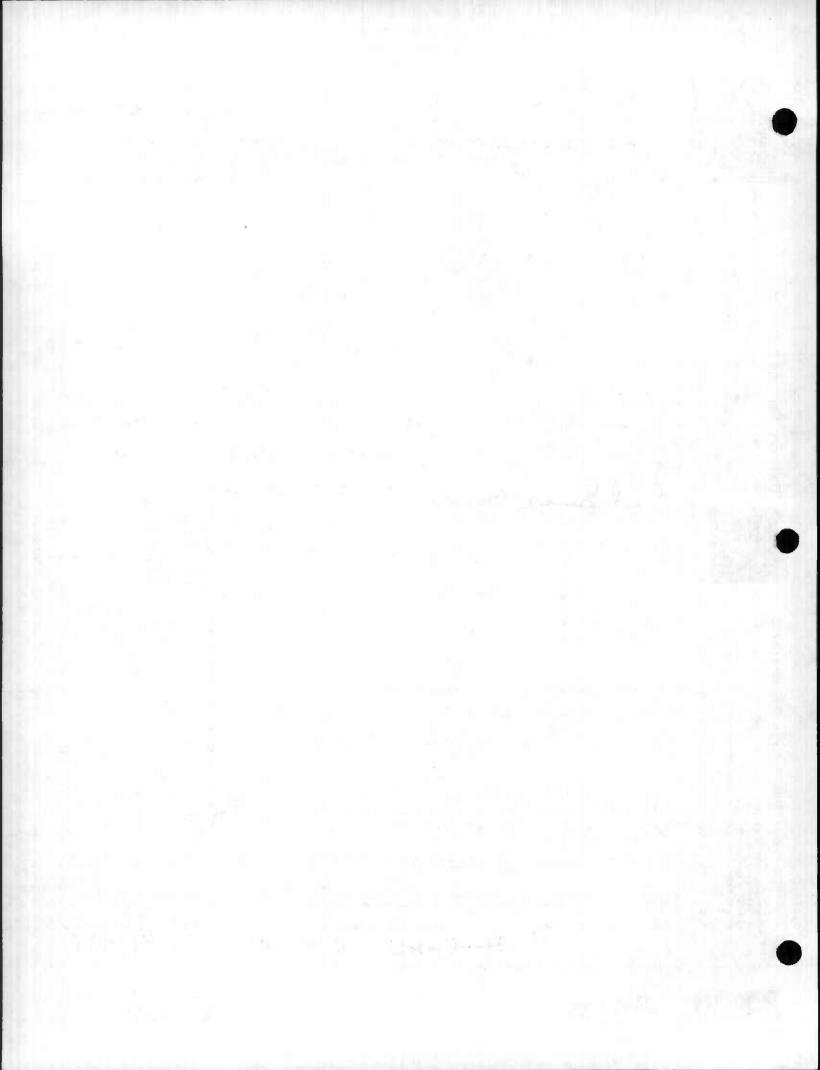
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Registrar

29b. Signeture end title of certifier

S. L. SANDHIR, M.D., 48 TARN TERRACE, FROSTBURG, MD 21532

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)



To Be Completed by Funeral Director	Usual Rasidanca of Decedant 10a. Stata 10b. County Maryland Washin 10a. Streat end Number 538 N. Mulberry 11. Marital Status 1□Navar Marriad 3□Widowed 4□Divorcad 15. Dacedant's Eder (Spacify only highast gra	DLZER a streat and number iex M 2X F 7 Ington 12. Wes Decedar Armed Force 1	Aga (In yrs. last bir 66 10c. City, Tow nt Evar in U,S. s?	thday) if Undar 1 Yaar Yrs. Days	Hours Min. 10 40 Hispanic Origin? (Spe	8. Date of Birth (Month, Day,) Dec. 2,	7 13, 19 4c. County of Was (aar)	shing Birthpla Country Mary	ca (State or Foreign y) 7 Land d. insida City Limits 1⊠ Yes 2□ No
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Be		0		clerk			donut	shop	
0	17. Father's Neme (First, Middla, Last)				18. Mother's Name	(First, Middle, Ma	aidan Sumama)		
	Charles R. Wallin	ig, Sr.			Josep	hine E.	Riley		
Ш	19a. Informant's Name/Ralationship (1			. Mailing Addrass (Straat	and Number or Rura	Routa Number,	City or Town, St	ata, Zip C	code)
		er - hus			erry, Hage	rstown,	Marylan	d 21	740
		Ramoval from Stat	· anmata	Disposition (Nama of y, cramatory or othar pla	ce)	Data 20	c. Location - Ci	ty or Tow	n, Steta
			Rest	Haven Cemet	tery 1-	15-98 H	lagersto	wn,M	aryland
	21. Signatura of Funerial Service Licen	100 /	7	Nama and Addra	ss of Facility MI	NNICH FU	NERAL H	IOME	
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	rasulting in death)	A	Due to (or as a c	onsequence of):	/			m	eseptet.
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an		d							
SICI	Part II. Other significant conditions co	ontributing to death	but not resulting in	tha underlying causa giv	ren in Pert I.	23b. Did tob	acco use contr	bute to t	he cause of death?
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	29b. Signeture end titla of certifier	/	0	29c. Licens	e number	290	l. Dete signed (I	Month, De	iy, Year)
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	30. Nama and eddrass of person who c	omplated causa of	daath (Item 23a) (Typa, Print)	0//)/		1/15/11	/	
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е	31. Date filed (Month, Day, Yaar)	32. Regis	trar's Signatura						
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	Medical Certification	Byron L. Oberholz 20a. Mathod of Disposition 1	Byron L. Oberholzer - hus 20a. Mathod of Disposition 1	Byron L. Oberholzer - husband 20a. Mathod of Disposition 1	Byron L. Oberholzer – husband 538 N. Mulbe 20a. Mathod of Disposition (Nama of Cemidal Contents) and Address of Donato 1 128 burial 2 1 Cremation 3 Ramoval from Stata 4 Donation 5 Others (Spacify) 21. Signatura of Funding Service Licensee	Byron L. Oberholzer - husband 538 N. Mulberry, Hage 20a. Method of Disposition 128 Burlar 2 Coremation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cemtaling, character) Commentary, character) Control place Commentary, charactery of Coremation, characteristic Commentary, charact	Byron L. Oberholzer – husband 20a. Mathod of Disposition 1 **Septial* 2 Cremation 3 Ramoval from State 4 Donaldon 5 Other (Specify) 21. Signatura of Funding Service Licensee 22. Nama and Address of Facility 22. Nama and Address of Facility 22. Nama and Address of Pacility MINNICH FU 22a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. 25a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. 25a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. 25a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest states of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest states. 25a. Parti Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest states. 25b. Wes case referred to medical way, leaving the cause of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest states. 25b. Wes case referred to medical way, leaving the cause of death but not resulting in the underlying cause given in Pert I. 25c. Wes case referred to medical way, leaving the cause of death but not resulting in the underlying cause given in Pert I. 25c. Wes case referred to medical way, leaving the cause of death but not resulting in the underlying cause given in Pert I. 25c. We	Byron L. Oberholzer – husband 20a. Mathod of Disposition 1 Separate 2 Creamation 3 Ramoval from State 4 Donation 5 Characteristics Characteristics Data 2 Creamation 3 Ramoval from State 4 Donation 5 Characteristics Characte	Byron L. Oberholzer - husband 538 N. Mulberry, Hagerstown, Maryland 21 20a. Mathod of Disposition 12 Bernal 2 Circension 3 Pannoval from State 4 Donation 5 Cohar (Spacity) 21. Signatura of Fundamental Survival Surviva

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State of Maryland / Department of Health and Mental Hygiene 8 0 1568

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and		Usual Rasidanca of Decedent 10e. Stete 10b. Cour	nty	10c. Cit	y, Town or Loc	ation				10d.	Insida City Limits
with the Marylan a or 28s-f show be notified at	ctor	Maryland Anne	Arundel			Dun	kirk				1 ☐ Yas 2XX\\o
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arnicete be executed ing physician and a es the buriel-transit	Medical Examiner	rasulting in death) Sequantially list conditions, if any, laading to Immediate causa. Entar Undarlying Causa (Diseasa or Injury that initieted avants rasulting in death) Last	6	Dua to (o	r as a consequer as a consequer as a consequer	ance of):	ma an	tas ta:	res.	1	year
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page	Com	Advanced	! Cerebr	vuage	wan.	Insu	Perchence	1 □ Ya	s 25 No	21200	as 2 No
this cartificete has trail director, page 2 s	To Be	25. Was case refarred to mediexaminar? 1 ☐ Yas 2 ☒ No	Hospital:	Inpatiant 2 🗆	EB/Outpationt	a∏ DOA Oth	26. Place of Dead	me 5 Reside		or (Conside)	
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4		30. Nama end addrass of person Gerald P. S			1 23e) (Type, P	rint)	Oratio	ngs, MD)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

					Certificate	of L	Death			Reg. No.	U	1000
Dhysia		1. Decedent's Name (First, Middle, L	ast)					2.	Date of De		Yeer	3. Time of Dea
Physici /Media		RICHARD		PHELP	S				Janua			2015
Examir		4a. Fecility Name (If not institution, garantee Calvert Memor:		tal.				wn, or Locat Frede	Ion of Deeth	4c. Count	y of Deeth vert	2013
Funeral Director			1₩ 2□ F	e (In yrs. lest birtho Yr	Months:	Year Days	If Under Hours	Min.	Date of Birl (Month, De uly 2	y, Yeer)		olece (State or Fontry)
ms 23a or 28a-f show	tor	10a. State 10b. County Maryland Calvert		10c. City, Town o	or Location ce Frede	ric	k				,	10d. Inside City L
a or 28a-f	Direc	10e. Street end Number 30 Industry Lane			10f. Zip 0	Code				10g. Citizen of		ntry?
al', or items 2:	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Fes, Give Yeer or Dates:	No	13. Was Decede If Yes, specif		spenic Orl n, Mexicar Specify:		y Yes or No an, etc.)		ce - Americack, White,	can Indian,
than "natural", or its	Completed	15. Decedent's Elementary/Secondary (0-12)	Education	16e. D	ecedent's Usual Give kind of work ife. DO NOT use	done d	lurina mos	t of working		16b. Kind of E	Business/In	dustry
al Hygi d other vent, t	То Ве Сош	17. Fether's Name (First, Middle, Las Wayne Phelps	8		_/Lawye	r		er's Neme (Fi		accoun		
Department of Health and Menin Important: If item 27 is marked any injury or other traumatic a once.		Rosemarie B. Phe. 20a. Method of Disposition 1 Deurial 2 Cremetion 3 I 4 Donetion 5 Other (Spec. 21 Signature of Funeral Servica Lice	□Removal from Stete	101 20b. Place of D cemetery,	Maling Address (Walnut Disposition (Neme cremetory or oth The Memor 22. Name end	Cove e of eer plece rial	Dr. 9) 1/1 Gard	Lusby 5/98 lens	Mar Dete		20657 City or To Mary	own, State
8 2 2 6		23a Part I Enter the disease or con	molications that caused	I the death. Do not	4405 Br			. Rd.	Port	Republ:		
hysician /Medical xaminer	ner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting In death)	e	Massi. Due to (or es e con	ul t				7 AO			Interval Betwee Onset and Dee
e attending physician and od for use es the burial-transit	Med	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that hittated events resulting in death) Lest	0.0	Due to (or es e cor	- 20	1	05	_ 0	ikę	,		unk
ache	Physician	Part II. Other significent conditions	contributing to death bu	ut not resulting in th	ne underlying cau	use give	n in Part I			obecco use co		o the ceuse of d
been sign should be	Completed by								24a. Was perfo	an autopsy med?	ev	ere eutopsy findi ailable prior to impletion of caus deeth?
this certificete hes ral director, page 2	Be Com	25. Was case referred to					36 Diago	of Deeth (C		res 2□No	1[⊒Yes 2□ No
0 0	ToB	exa <i>m</i> iner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2□ER/Outpa	atient 3D DOA	Othe	P*			dence 6 Ot		(v)
After fune	Certification:	27. Menne of Death 1 Alaturel 5 Pending 2 Accident investigation	1015-1	y Year) 28b. Tim		Wark		28d		now Injury occu		
0 to >	=	3 Suicide 6 Could not to determined		ury - At home, farm	, street, factory,	offica		28f.	Location (S City or Tox	Street end Num vn, Stete)	ber or Rura	al Route Number,
ral Direction by				f my knowledge d	eath accurred at	the time	a data an	d =1=== ==d	due to the	cause(s) and m	enner es s	tated
24 hous afte Funeral Dire	edicai	one) 2 Medical Exa	hyalcien: To the best of miner: On the basis of end manner sta	examination and/o	or Investigation, Ir	n my op	inlon, dee	th occurred a	at the time,	date and ptace	, end due to	the cause(s)
		Check only 2 Medical Exa	miner: On the basis of	examination and/o	or Investigation, Ir	n my op	number	th occurred a	at the time,	date and ptace 29d. Date sign	, end due to	Dey, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Daeth 3. Time of Death January 6, 1998 **Physician** 1:30 PM ANDREW PELTZ /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Daeth Examiner 502-D Lynnehaven Drive Hagerstown Washington | Months | Days | Hours | Min. | August 27,1916 | West Virginia 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2□ F Months 235-09-5255 81 Director Usuel Rasidance of Dacedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23e or 28e-f show other traumstic event, the Medical Examiner must be notified at 10d. Insida City Limits Director Maryland Washington 1X Yas 2 No Hagerstown 10e. Straat and Number 10f. Zin Coda 10g. Citizan of What Country? 502-D Lynnehaven Drive 21742 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, White, etc. 1 X Yas 2 □ No If Yas, Giva Yaar or Datas: WW II 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ XNo Specify: Specify: White g 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "n any injury or other traumatic event, are Medonce. Elamantary/Secondary (0-12) 12 College (1-4or 5+) Layout Inspector Aircraft Mfg. 17. Father's Nama (First, Middla, Last) 18, Mother's Neme (First, Middle, Majdan Surnama) Be Peltz Joseph Anna Galajda 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Robert L. Shoop 18529 Sherbrooke Drive, Hagerstown, Md. 21742 20b. Placa of Disposition (Nama of cemetary, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata N☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 01-09-98 Hagerstown, Maryland 21. Signatura of Funeral Service Lice 22. Nama and Addrass of Facility
Andrew K. Coffman Funeral Home, Inc. R heel Bredy 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath **Physician** Apparent heart attack
Dua to (or as a consequence of): /Medical Immediata Ceusa (Final instant diseasa or condition rasulting in daath) Examiner physician and s the burial-transit certificate be axecuted Saquantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in death) Last Due to (or as a consaguança of): Box 68760, Physician/Medical Due to (or as a consequence of): ettending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by Chronic gastritis Records. g 8 cata hes been significant page 2 should b 24b. Wera eutopsy findings available prior to Completed 24a. Wes an autopsy performed? complation of causa of death? 1 Yas 2 PNo certificata 1 ☐ Yas 2 ☐ No of Vital Be 25. Was casa rafarrad to madical 26. Placa of Daeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yas 25 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) this To the Hospital or Attending Pr within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Daath 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Natural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28e. Plece of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyalcian: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Llcansa number 29d. Data signed (Month, Dey, Year) Horold R Truth ON 30. Nama end addrass of parson who completed causa of daath (Item 23e) (Type, Print)

348 mill ST HAGERSTOWN AND 21740

State

Registrar

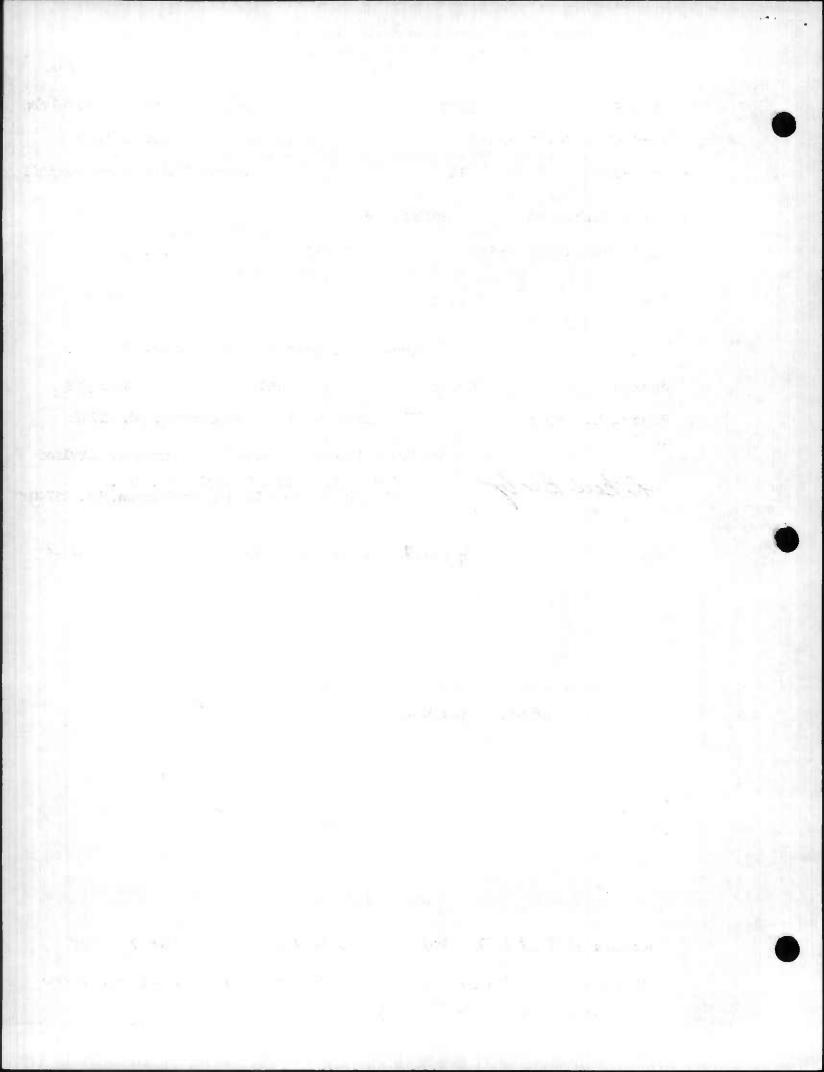
IHAROCO RTRITCH

JAN 07

31. Data filed (Month, Day, Yaar)

32. Ragistra's Signature

Suha Davidson

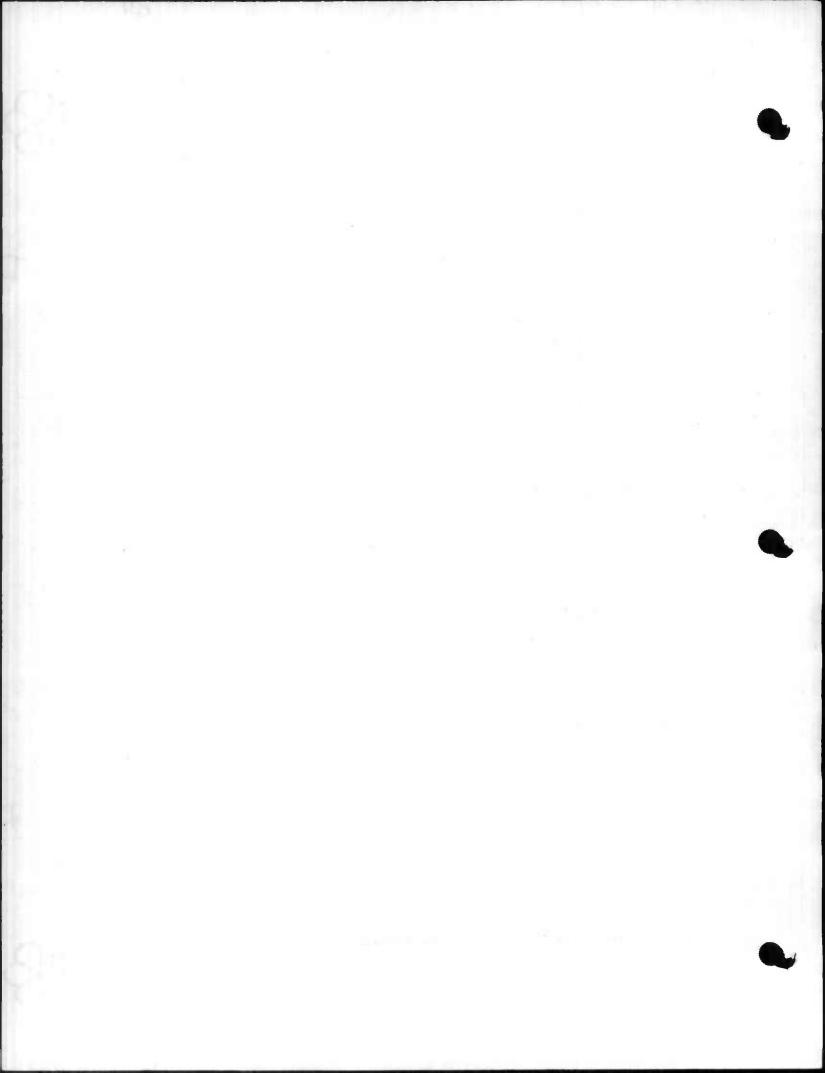


BALTIMORE, MARYLAND 21215-0020	ath. Page 6 may be retained by the hospital or attending physician.	
BA	nours after de	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	the Principles and the second

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL	HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Lest)		2. DATE O	F DEATH

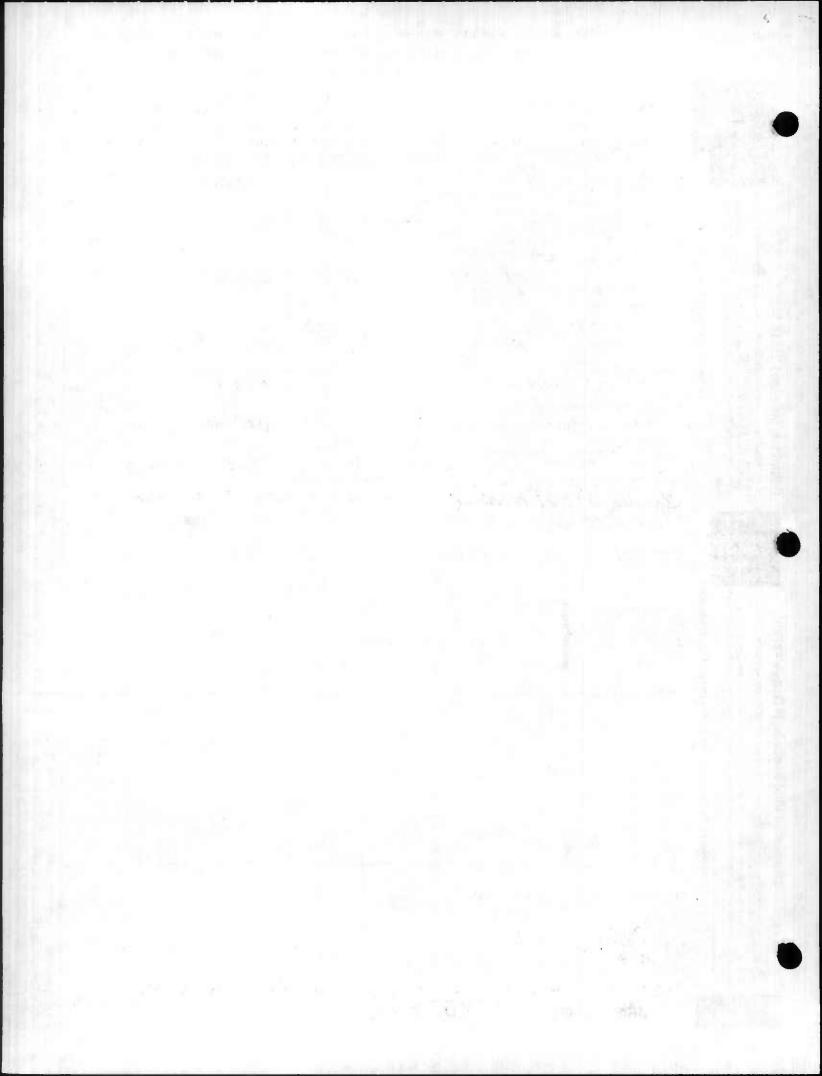
	1. DECEDENT'S NAME (First, Middle, Lest	ŋ					2. DATE	OF DEATH		3	. TIME OF DEATI
	ROBERT SULLIV	AN PURCE	LL				JANU	DA		98	8:26
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 YEAR		7. DATE (OF BIRTH		a. BIRTHPL	ACE (State or For
	258-36-6225	1 🔀 M 2 🗌 F	72.	YRS.	MONTHS DAYS	B HOURS MIN.	NOV.	76 1	925	CEOI	RGIA
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOW	N OR LOCATION OF		10, 1		NTY OF DEA	
R	WESTERN MARYLAN	D HOSPITAL	CENTE	R		HAGERST	OWN		1	WASHI	NCTON
5	RESIDENCE OF DECEDENT		OZZITZI				OWIT		<u> </u>	121371111	NOTON
DIRECTOR	10a. STATE 10b. COUN			10c. CITY,	TOWN OR LOC	CATION				10	Od. INSIDE CITY
- 10	MARYLAND	WASHINGTO	<u>N</u>				SBORO			1	YES 2 🗌
₹	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITI	ZEN OF WHA	AT COUNTRY?
FUNERAL	121 SOUTH MAIN	T					713			U.S	.A.
교	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	ARMED	13. WAS D	ECENDENT OF HISP specify Cuban, Mexi	ANIC ORIGIN	(Specify Year	or No-		- American India White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES	-3		ES 2 NO Spec		, , , , ,		Specify:	
<u>a</u>	15. DECEDENT'S ED	HICATION	10- 1	DECEDENTIS	JSUAL OCCUPA	7.00	L				WHITE
E I	(Specify only highest grad	de completed)		(Give kind of wo	ork done during i	most of working	160.	KIND OF BUS	INESS/IND	USTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5+)						DD TA	TDT 170	COLE	43777
COMPLET	17. FATHER'S NAME (First, Middle, Last)			SALI	ESMAN	18. MOTHER'S N	AMP (F)			COMP	ANY
_	GEORGE D. PURC	FI.I.							sumame)		
B	19a. INFORMANT'S NAME (Type/Print)	EDL		19h MAII INC	Annese /o-	EDNA S	-		One of	0-4-	
임	ETHELYN H. PURCE	II /CDOUCE				et and Number or Rurs					D 01710
	20a. METHOD OF DISPOSITION	TT/ SECUSE			JIH MAI	IN STREET					
	1 X Buriel 2 Cremation 3 Red 4 Donation 5 Other (Specify)	moval from State	cemelery, c	crematory or oth	er place)		DATE			Cify or Town	
	21. SIGNATURE OF PUHERAL SERVICES	ICENSEE	IFAIR	VIEW C	EMETER NAME	AND ADDRESS OF I	1/9/98	KEE	DYSVI	LLE.	MARYLA
	120m/1		M Da				.,	7606	01d	Natio	onal Pil
	TOWN PHILL	au Paul	m. Dea	an	BAST	FUNERAL	HOME			, MD	21713
7	disease or condition resulting in death)	a. REA			-	126					2 me unknown 3 years
<u> </u>	Sequentially list conditions, if any, leading to immediate	b. DUE TO (C	OR AS A CONS	EOUENCE OF)	ALLITA	23			2		1 01.7
CATION	cause. Enter UNDERLYING CAUSE (Disease or injury	· CER	EBRO	VASC	MAR	, ACCIO	ENT	7			3 year
RIF	that initiated events	DUE TO (C	R AS A CONS	EOUENCE OF)	:						0 .
医胃	resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF)						×		i
W III		d			X						X
빙	PART II. Other significent condition	d.	eath but not	regulting !-	X the underlyi	ing cause cluss !	David I	944 MAP ***	ALITARO:		X
빙	PART II. Other aignificent condition			t reaulting In	the underly	ing cause given i	n Part I,	24a, WAS AN A		AV	MILABLE PRIOR T
빙	PART il. Other aignificent condition	one contributing to d		t resulting in	the underlyi	ing cause given i	n Part I,		MED?	AV	MILABLE PRIOR 1
MEDICAL CE		na	re					PERFOR	MED?	AV CC Of	MILABLE PRIOR TOMPLETION DE CA
MEDICAL CE	DID TOBACCO USE CON	na	SE OF DE	ATH YES	S 🗆 NO	☐ UNCERTA		PERFOR	MED?	AV CC Of	MILABLE PRIOR TOMPLETION DF CATH?
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MEDICAL CE	DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAU	SE OF DE 26, PL/	ATH YES	MO OTHER:	UNCERTA Dome 5 Residence	IN D	PERFORI	NO NO	AV CC OF	MILABLE PRIOR TOMPLETION DE CA
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State of Maryland / Department of Health and Mental Hygiene

Physic	ian	1. Decedent's Name (First, Middle, Last)		R I CO			2. Date of De Month		Year	3. Time of Death
/Medi		Guy Briggs Pe					Jan. 6			10:00 A. N
Exami	ner	4a. Facility Name (If not Institution, give					Location of Deat	1.161.27.57		
		509 N. Mulberr 5. Social Security Number 6. Securit		In at historia.	If Under 1 Year	Hagersto			shing	
Funeral Director			7. Age (in yrs 68		Months Days			tn, Year) 9, 1929	9. Birthp Cour Washi	place (State or Foreign ntry) ngton, D. C.
dand w		10a. State 10b. County	10c. C	ity, Town or Loca	ation				1	0d. Inside City Limits
Man,	to	Maryland Washing	ton	Hager	stown					1∰ Yes 2□ No
or 28	Director	10e. Street end Number	E1624 1.111		10f. Zip Code			10g. Citizen of \	What Cour	ntry?
th will		509 N. Mulberr	y Street		2:	1740		USA		
13-UULU 72 hours after death with the Manyland "natural", or items 23a or 28a-f show offest Evanther must be notified at	by Funeral	11. Marital Status 1 TNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		as Decedent of res, specify Cub	Hispanlc Origin? (ean, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - Americ ck, White, : Whi	etc.
n 72 hou		15. Decedent's Educ	cetion	16e. Deceder	nt's Usual Occu	pation		16b. Kind of B	usiness/Inc	dustry
within ene.	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)		nd of work done NOT use retire Stimato:	pation during most of wo d)	orking	cold st	orage	doors
tal Hy	To Be C	17. Father's Name (First, Middle, Last) Guy Briggs Pend	leton				ame (First, Middle Irene S		10)	3/10/
2 should and Men is marke	1	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing	Address (Stree	t and Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code)
alth a 27 is		James R. Pendle	ton Broth	er 712 M	ledway R	oad Hag	erstown,	Maryla	nd 2	21740
s 1 en f Heal fem 2		20a. Method of Disposition	20b.	Place of Disposit	tion (Neme of	ice)	Date	20c. Location -	City or To	own, State
Samit, Pages 1 e Department of He mportant: If Nem nny Injury or other ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	annoval front State	gerstown			1/12/98	Hagerst	own.	Maryland
permit. Pa Departmen Important: any injury once.		21. Equature of Funeral Service License			Name and Addr		-11 50	11000100		
Physician /Medical Examiner		23a Fart1 Enter the disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	Chymic	OZstru	chre	AU/w	ory (Mrak		Interval Between Onset and Death In Lum In Pum In P
2 H	iner		Resher	U. N.C.	lux	Olycon	2		(ya pura
be execute ician and burtal-tran	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence all					
Illicate g phys as the	/Medical	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
death cerr e attendin d for use	iclar	Part II. Other significant conditions cont	ellution to death but not read	sulting in the condi	adden corres of	unn in Part I	22h Did	tahacan usa na	atelbushs to	the cause of death?
d by th	y Physician/N	The state of the s	receiving to detail out the re-	solong in the unor	arysig cause gr	net in Part I.	VI NO	Yes 2□ No		pebly 4 ☐ Unknown
diciart. The law requires to cartificate has been signe rector, page 2 should be	Completed by							an autopsy med?	ava	ere autopsy findings silable prior to impletion of cause death?
The law ate has page 2	E O						101	res 200/No	10	Yes 2□ No
cient: The sertificate vector, pag	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o	ne)		
Physician: rhis cardio ral director,	To	examiner?	ospital: 1 inpatient 28	ER/Outpatient	3C) DOA O	hater	Home 5 TResid		er (Specify	0)
the the		27. Manner of Death 1 €Natural 5 ☐ Pending 2 ☐ Accident investigation	28s. Date of Injury (Month, Day Year)	28b. Time of Injury	M 10		The second secon	now injury occur		
2 E E C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street fy)	t, factory, office		28f. Location (: City or Tox		er or Rum	l Route Number.
Hos Pun Pun etaly	edical	29a. Certifier (Check only one) 1 Certifying Physical Examin	clan: To the best of my known: On the basis of examination and manner stated.	owledge, death or ation and/or inves	courred at the ti	me, date and plac opinion, death occ	e, and due to the urned at the time,	cause(s) and ma date and place, :	inner as st and due to	ated. the cause(s)
To the within To the compl	Me	29b. Signature and Jule of certifier	M).		29c. Licen			29d. Date signe		Dey, Year)
3		TPI	עוו		D'	+1388	5	1,12	,98	
1		30. Name and ad ress of person who con	mpleted cause of death (Item	m 23a) (Type, Pri	int)		1 A 11.			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1:58 pm BARBARA PRICE 1998 JANUARY 6 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth BAYVIEW HOSPITAL JOHNS HOPKINS Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9 / 3 0 / 1 9 3 0 If Under 1 Year
Months Deys 9. Birthplece (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1□ M & F 13-28-3245 67 Yrs. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road 21219 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) cable assembler automobile 12 th 17. Fether's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Meiden Surneme) Arthur Strawderman Nettie McCaulev 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rt 1 Box 206 BB Martinsburg, WV 25401 Jeannie M. Kneisly 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removei trom State 1/7/98 Martinsburg, WV 2540 Rosedale Crematory 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Rosedale Funeral Chapel, Inc 2060 Rosedale Rd., Mtsbg, WV 25401 | 2060 ROSECATE RO., 170509

23a. Parkt. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Vackwaits Approximete. Intervei Between Onset end Deeth Immediate Ceuse (Fine) NTRACRANIAL -12 HB diseese or condition resulting in deeth) Due to (or es e consequenca of): TROKE DAYS Due to (or es e consequence of): ATRIAL FIBRILLATION Due to (or es e consequenca of): ARDIAL YOC INFARCTION 23b. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were eutopsy tindings evelleble prior to completion of cause of deeth? 24e. Was en eutopsy performed? 1 Yes 2 No 1 Tyes 2 No. 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner

that the death certificate be executed

Records, P.O. Box 68760

Division of Vital Attending Physician:

permit. Pages Depertment of Important: If II any injury or o

Physician

/Medical

Examiner

10a State

Md.

Director

Funeral

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Completed

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryland neat of Heeth and Mental Hygiene. In neat of Heeth and Zi ar marked other than "netural", or Herns 23a or 28e-f show int: If them 27 is marked other than "netural", or herns be nothing a rry or other traumatic event, its Medical Example must be nothed as

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last physician end the burial-tran Physician/Medical as esn 0 deteched signed I

à

Completed

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Certification:

Medicai

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After

i or Attendin efter deeth. Director: Aft

Hospital or Atte
 24 hours efter de
 Funeral Directo

To the Hosp within 24 ho To the Fune completely f

funeral director,

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

25. Wes case reterred to medical 1 Yes 2 No 27. Manner of Deeth

28a. Dete of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Plece of Injury - At home, tarm, street, fectory, offica building, etc. (Specify)

28c. tnjury et Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 MNaturel

2 Accident 3 Suicide

4 Homicide

🔀 Certifying Phyetcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and menner stated.

29b. Signeture and title of cartities

29c. License number

29d. Date signed (Month, Dey, Year)

993

6 ☐ Could not be

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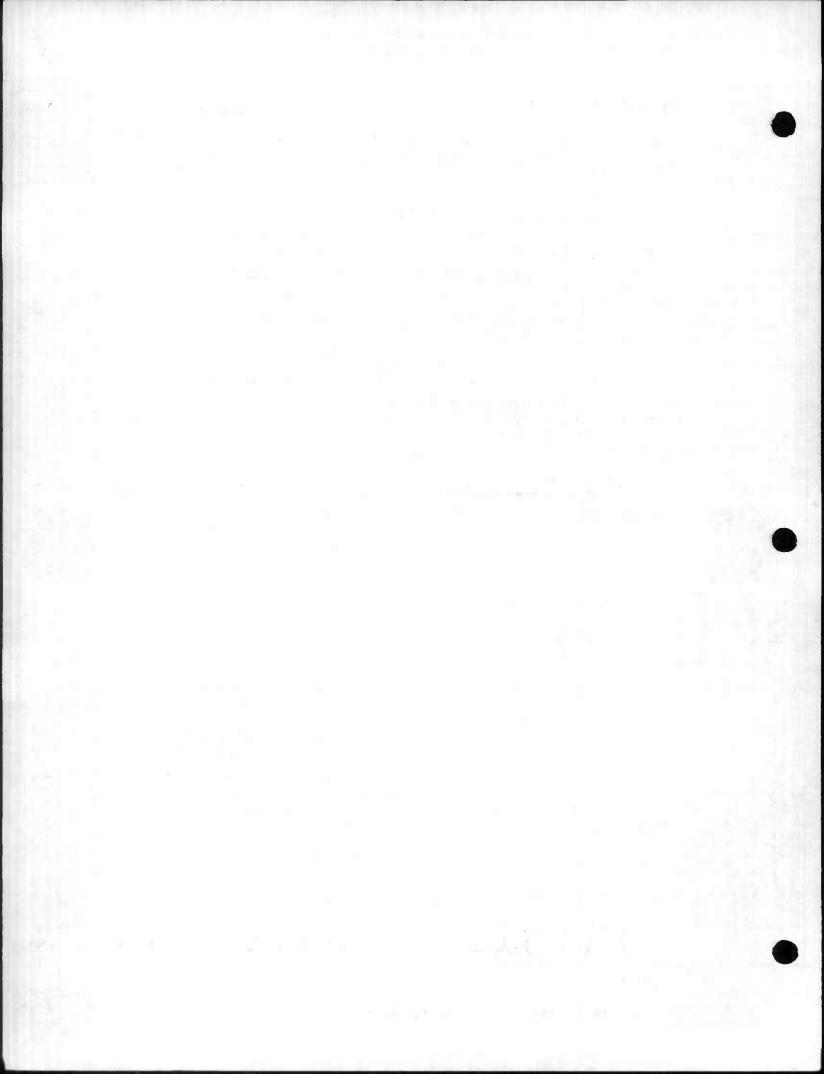
TAHNART

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) KELEMEN mD MARIL

State Registrar 31. Date tiled (Month, Day, Year) JAN 07

32. Registrer's Signeture Tulia Davidson



Phys /Me Exar

Funer Directo

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is Modical Examiner must be notified at

Physician /Medica

Examine

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit

Please Type or Print in Black Indelible Ink	. Assure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene 574 Certificate of Death

П	П	1. Decedent's Nam-	e (First, Middle, La	st)						of Deeth			3. Time of Deeth
cia		Wilson P	erishing	PRYOR					Tan	UARY	беу	Yeer 1998	2150
lica ine		4a. Fecility Name (/	f not institution, giv	e street and number)			4b. City, Tow	m, or Location o	The state of the s	c. County	110	
		Washingto	on County	Hospital				Hagers	stown		Wash	ingto	n
1		5. Social Security N	umber 6. S	Sex 7. A	ge (In yrs. les	t birthday)	If Under 1 Year		4 Hrs. 8. Date	of Birth	e)	9. Birthple	ece (Stete or Foreign
r		220-09-8	867	ØM 2□ F	79	Yrs.	Months Days	Hours		18,191		Mary	
		Usual Residence of			1				10.0				
	_	10a. State	10b. County		10c. City, 1	Town or Loc	cation					10	Od. Inside City Limits
	cto	Maryland	Washingt	on	Will	iamsp	ort						1 X Yes 2 No
1	Dir	10e. Street end Nur					10f. Zip Code			10g. C	itizen of V	Vhet Count	try?
	8	13 North	Vermont	St.			217	795			USA		
	Funeral Director	11. Marital Status		12. Was Deceden Armed Forces	?	13. W	Vas Decedent of Yes, specify Cub	Hispanic Orlg	in? (Specify Yes	or No-		e - Americe k, White, e	
			ed 2 Married	1 X Yes 2 ☐	No 1942	_	☐ Yes 2 No				Specify		
	d by	3 Widowed		Year or Dates	1940		^					*****	
	Completed	(Spec	 Decedent's En ify only highest grant 	ducetion ade com <i>pleted)</i>		6e. Deced	ent's Usual Occu kind of work done OO NOT use retire	petion during most	of working	16b.	Kind of Bu	usiness/Indi	
	du.	Elementery/Seco		College (1-4or	5+)		t Metal			Sar	dhla	sting	Equip. Manuf.
		17. Fether's Neme	Tiret Middle Last			31166	rietat	1	's Name (First, I				manui.
	Be		1.1	-					,	vilgale, ivialue			
1	2	Frank 19a. Informent's Na	W •	Pryor		10h Mailin	g Address (Stree	Lilli		At	Wa		On to
		Clara Mai					Vermont						Code)
		20e. Method of Disp		/ 1110	20b Plec		sition (Neme of	31. 1	Dete			City or Tov	un State
		1X Burial 2	Cremation 3	Removel from State	cem	etery, crem	atory or other ple						
			5 Other (Specif		Gree	-	Mem. Pa			WII	. I I am	sport	,Maryland
		21. Signature of Fr	neral Service Lice	9//	/	0	Sborne F	ess of Facility Tuneral		425 S.	Cono	coche	ague St.
		Cu	rig/	. Ca	5-	_				Willia			21795
		23a. Pert1. Enter the shock, or hear	ne dist ase, or com it favore. List only	plicetions thet cause one ceuse on each	ed the death. I	Do not ente	r the mode of dy	ng, such es c	erdiac or respire	etory errest,			Approximete Intervel Between
1	1		/		^	n .	1		A				Onset end Death
ı		Immediate Ceuse (disease or condition		e Mes	hon.	tai	luro	- Ch	cello-				10 days.
ı.	_	resulting In deeth)			Due to (or es	s e censequ	uence of):		,	۸			0
	Ē			b Chr	onic	luc	mpho	cutic	leu	ben	nia	• I	10 years
	Examiner	Sequentielly list con	nditions,		Due to (or es	s e contequ	ence dr):	- 1					9
		Sequentially list con if any, leading to Im- ceuse. Enter Unde Ceuse (Disease or that initiated events	rlying Injury	c									
1	an/Medical	resulting in death) L	est		Due to (or es	e consequ	ence of):						
	NW.			d									
	Slan												
	Physici	Part II. Other eignifi	cent conditions o	ontributing to death	but not resultir	ng in the un	derlying cause gi	ven in Pert I.	238	o. Did tobeco	o uee cor	ntribute to	the cause of death?
d	5	Thro	noon.	to be n	ior.					1 Tes	2DXNo	3 Prob	ably 4 Unknown
3	Completed by	11102	1	11000							V	Data 14/-	no action on the disease
	ete	New	trope	nia.					248	. Wes en eut performed?	opsy	6V6	re eutopsy findings ileble prior to apletion of cause
	<u>d</u>		1									of d	leeth?
6	3									1 ☐ Yes	2 No	1 🗆	Yes 2□ No
8	e a	25. Wes cese referrences	ed to medicel	Hamilat No.					of Deeth (Check	only one)	7 \		
1	9		No	Hospital: 1 Inpat		/Outpatient	3LI DOM		sing Home 5)
i	0	27. Menner of Deeth	5 Pending	28e. Dete of Inj (Month, D	ury ey Year) 28	b. Time of Injury	28c. Inju			scribe how Inj	ury occurr	ed	1 1 7 1
1	cat	2 ☐ Accident 3 ☐ Suicide	investigation				M 1]Yes 2□N					
1914	Certification:	4 ☐ Homicide	determined	286. Place of Ir	jury - At home tc. (Specify)	, farm, stre	et, fectory, office		28f. Loca City	ation (Street a or Town, Ste	and Numb ote)	er or Rural	Route Number,
3	3		V										
100	edical	29a. Certifier (Check only	12 Certifying Ph 2 Medical Exam	yeiclen: To the best niner: On the basis of	of exeminetion	dge, death end/or inve	occurred et the ti	me, date end opinion, deeth	plece, end due occurred et the	to the ceuse(s) end me	nner es ste	eted. the ceuse(s)
	De E	One)		end menner s	tated.								
		29b. Signature and	rue ordenner	0	1		29c. Licen	se number	70	29d. D	ate signed	d (Month, D	Dey, Yeer)
		Th	t bu	1a.	al	on	10	hbh	113	4	1/6	14	8
		30. Name end addre	ess of person who	completed cause of	deeth (Item 23	Ba) (Type, P	Print)	0	10	#	das	rste	an, ma
		Tind.	Hame	dan, M	D; 3	563	S. C	level	and H	le:	2	21	740
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Yeer **Physician** Month Gladys Louella Pound 3 2025 Januara 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deetly 4c. County of Deeth **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth Month, Day, Year) 12 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Maryland 1□M 2√2 F 214-09-7059 85 Yrs. Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examination in at the noffied at Keedysville 1 ☐ Yes 2 No Director Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21756 U.S.A. 5332 Mt. Carmel Church Rd. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: py Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Meda, once. Elementary/Secondery (0-12) College (1-4or 5+) Secretaru Auto Dealer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Barbara E. Ernst Raymond E. Hause 19e. Informent's Name/Reletionship (7/89-37iphal 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Representative 5332 Mt. Carmel Church Rd. Keedysville, Md. 21756 Della Thompson 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 DB 1998 Donatio Smithsburg Crematory 5 Other (Spe) Smithsburg, Md. uneral Service L 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) **Examiner** The law requires that the death certificete be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pue Due to (or es e consequenca of): physiclen Box 68760 Physician/Medicai the Due to (or es e consequence of): attending | P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 7 woe Records, ò 24b. Were eutopsy findings eveileble prior to Completed 24e. Was en eutopsy ennous completion of cause of deeth? page 2 s has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Maturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year)

Itagensta

State Registrar 29b. Signature

31. Date filed (Month, Day, Year)

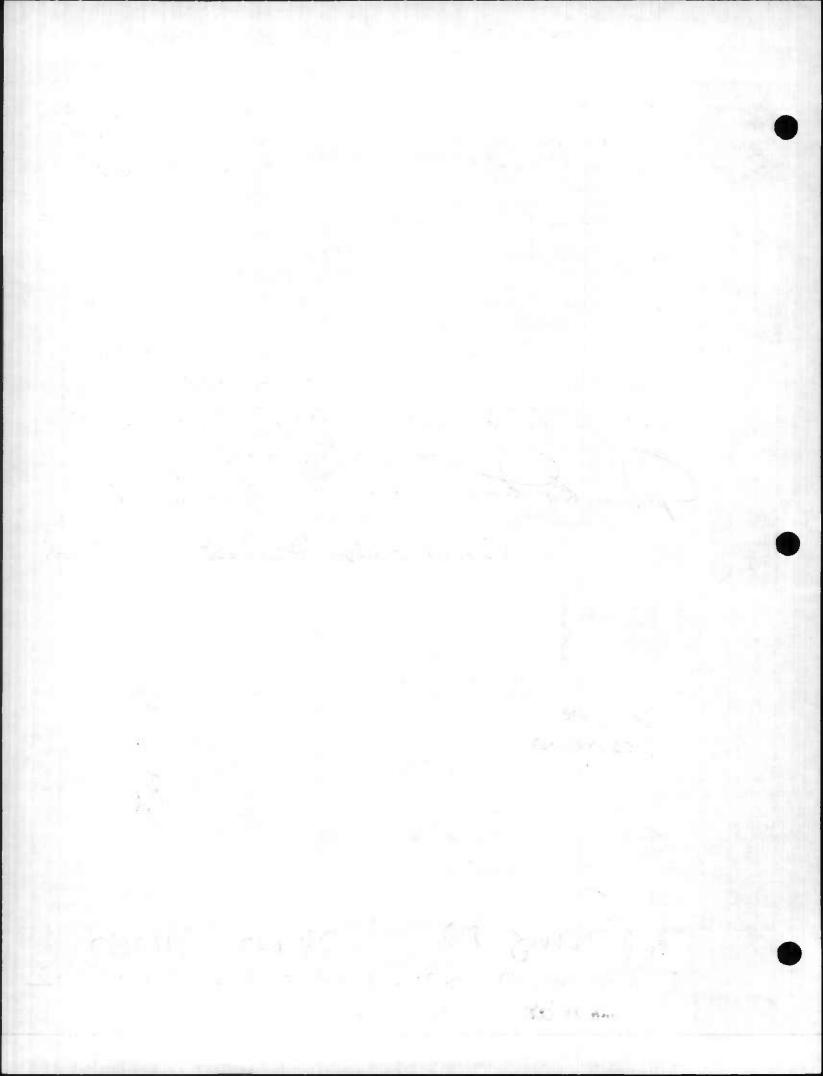
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32. Registrar's Signature

ulia Davidson

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Vee Elsie Viola PRICE 1998 Jan. 1:15 p.m. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington Homewood Retirement Center Williamsport 7. Age (In yrs. lest birthdey) | If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 6. Sex Birthplece (Stete or Foreign Country) 1□M 2⊠F Months Deys Yrs. March 15 1900 213-74-0523 Maryland Usuel Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 250 Pangborn Blvd. 21740 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Her own home Homemaker 17. Fether'e Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Harry Rubeck Margaret Shaefer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Price - Son 10810 Oak Forest Drive Hagerstown, Maryland 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1 - 5 - 98Rest Haven Cemetery Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Negme end Address of Fecility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequenca of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation

burial-transit pue physicien certificete be the ettending i for use as ed by the e signed t Records, has this certificate After deeth. Director:

Physician

/Medical

Examiner

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r than "natural", or items 23a or 28s-f show the Medical Examinar must be notified at

filed within 7 Hygiene.

1 and 2 should be filed w feelth end Mental Hygier m 27 is marked other th

permit. Peges 1 and 2 sh Department of Heelth end Important: If Item 27 is m any injury or other traum

Physician /Medicai

Examiner

the Maryland

altimore, Maryland 21215-0020

Physician/Medical þ Completed Be 2 Certification: To the Hospital or A within 24 hours effer To the Funeral Direc completely filled in by

29e, Certifier 29b. Signeture and title of

3 Suicide

4 Homicide

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

the Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated.

6 Could not be determined

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

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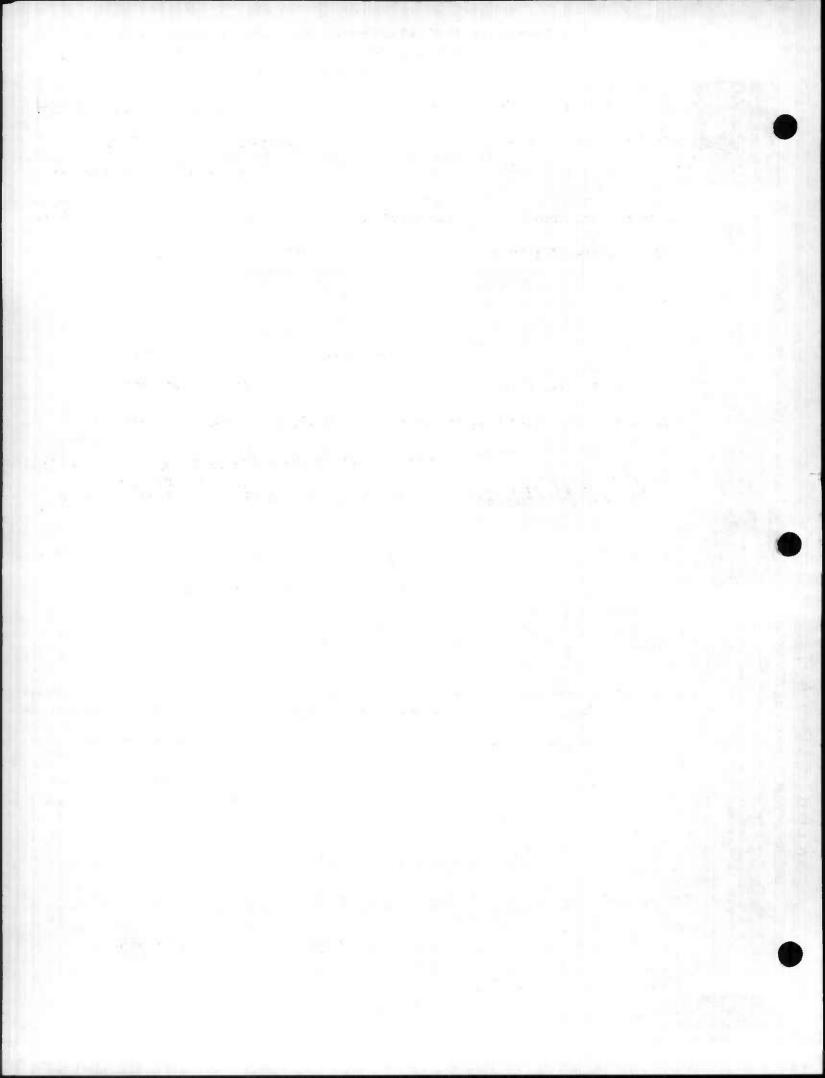
Medical

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State of Maryland / Department of Health and Mental Hygiene 8 0 | 57

Physicia					Certifica	ALC OI	Dealii	Re	eg. No.		
	an	1. Decedent's Neme (First, Middle, La			HHA			2. Dete of Deet	h	Voor	3. Time of Deet
/Medic		Beulah	Armatha Rl	ENNER				January	Day	1998	2354
Examin	er	4e. Fecility Name (If not institution, give				-	4b. City, Town, or	Location of Death	4c. County	y of Deeth	
		Washington Count					Hagerst			ingto	n
Funeral Director		215-14-1786	Sex 7. Age 1	(In yrs. lest bir 86	Month	ler 1 Year s Deys	Hours Min.		Year) 1911	9. Birthpl Count Penn	ece (State or Ford lry) Sylvania
* * *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Lin
de	ō	Maryland Washing			nsville	2					1 ☐ Yes 2·☐
288 notif	Pec	10e. Street end Number		114484		Zip Code		41	0g. Citizen of	What Count	lm/2
ms 23a or 28a-f show	Funeral Director	14020 Village Mi					21767		U.S.		ny i
al', or its	by	11. Meritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Dates:				dispanic Origin? (S an, Mexican, Puerl Specity:	specify Yes or No- to Ricen, etc.)		ce - America ck, White, e y: wh	
natural',	je d	15. Decadent's Ed (Specify only highest gra	ducetion	16e.	Decedent's Us	suel Occup	etion during most of wor	ting	16b. Kind of B	usiness/Ind	ustry
- 40	Completed		Cotlege (1-4or 5+))	life. DO NOT	use retired	d) most of word	rking			
Hygiene. ther then ant, in We	5	Elementary/Secondery (0-12)	0,		urses a	asst.			hosp	oital	
d oth	Be (17. Fether's Neme (First, Middle, Last,					18. Mother's Nan	ne (First, Middle, M		,	
nd Mentel marked o umatic eva	10	Harry V.	Hamby					Susie F.	Binga	ıman	
end si m		19e. Informent's Name/Reletionship (Mrs. Laura Howell						ural Route Number, erstown.			Code)
Health em 27 ther tr		20e. Method of Disposition	, 8		Disposition (N		out, mag		20c. Location	-	
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Renner, Beulah



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month Vaar **Physician** 2:00 p.m. 1998 Vinnie Gertrude RODGERS Jan 8 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 450 Stratford Avenue Washington Hagerstown 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. 6 Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1□ M 2K) F Months Days Hours Yrs. Director 214-09-5707 87 26 1910 Virginia Usual Rasidanca of Dacedant 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Mauical Examinal must be notified at 10d. Insida City Limits 1 Yas 2 □ No Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 450 Stratford Avenue 21740 Funeral U.S.A. 12. Was Decedent Evar In U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 11. Marital Status Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: þ White Specify: 3 XWidowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Her own home 17. Fathar's Nama (First, Middla, Last) 18, Mother's Nama (First, Middle, Maidan Surnama) Be permit. Pages 1 and 2 should be to Department of Health and Mental Important: If Item 27 is marked or Edgar Vernon Ramey Gertie Mae Kendrick 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 7036 Tommytown Road Mrs. Louise Hartle - Friend other i Sharpsburg, Md. 21782 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 0 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Cedar Lawn Memorial Park 1-12-98 Hagerstown, Maryland 21. Signature of Foreral Service Licensee 22. Nama and Addrass of Facility In y Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cerdiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximata Intarval Batwaan Onsat and Death Physician nstant /Medical Immadlata Ceusa (Final disaasa or condition rasulting in daath) Examiner Examiner Saquantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or Injury that initiatad evants resulting in daath) Last Dua to (or as e consequance of): Physician/Medical Due to (or as a consequence of): as Part II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by Completed 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to complation of causa of death? Be 2

certificete be executed physician and s the bunal-trans P.O. Box 68760, ettending p The lew requires that the death signed by the e Records, Division of Vital Hospital or Attending Physician: filled in by the funeral director, this Certification: deeth. within 24 hours efter deet To the Funeral Director: completely filled in by the

the

72 hours efter

Baltimore, Maryland 21215-0020

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3 ☐ Suicida 4 ☐ Homicida	6 Could not be datarmined	28a. Place of Injury - At building, atc. (Space	homa, farm, straa	it, factory, of	ffice	28f. Location (Strea City or Town, S		er or Rural Route	a Number,
9a. Cartifiar	1 Certifying Ph	vsician: To the bast of my kr	nowladga daath o	occurred at the	ha tima data and plac	and due to the cause	a(c) and man	ner as stated	

29b. Signatura and titla of certifiar

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

MO addrass of person who complated causa f death (Itam 23a) (Type, Print)

PIKE 5. Z 31. Data filad (Mont

State Registrar

Medicai

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 0546 Mary Elizabeth ROWLAND 1998 January 6 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 K F 216-10-6069 Yes Director 83 July 23, 1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frams 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at Washington Maryland Williamsport Director 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16523 Spielman Road 21795 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No by Specify: 3 X Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be filt mant of Haalth and Mantal Hy lant: If Itam 27 Is marked oth Jury or other traumatic event Be 2 Baker Harry Annabelle Hammond 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kimberly K. Forsyth/Grd.daughter 1425 S.Potomac St. Hagerstown,MD 21740 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If eny injury or once. Greenlawn Mem. Park Jan.9,1998 Williamsport, Maryland 22. Name end Address of Fecili 425 S.Conococheague St. Osborne Funeral Home Williamsport, MD 21795 23a. Pert1. Entof the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) instant Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Physician/Medicai Due to (or es à consequence of): signed by the at d be datached fo Pert ti. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 2 No 112 Yes 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy been : has this certificate 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No Attending Physician: funeral director. Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Monpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident daath in by the Director 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) or A after 4 Homicide Hospital 24 hours 8 24 hours 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier

State Registrar

80 NAL

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)



29c. License number

29d. Date signed (Month, Day, Year)

pr. Williamsport nd

21215-0020

Baltimore, Maryland

Box 68760.

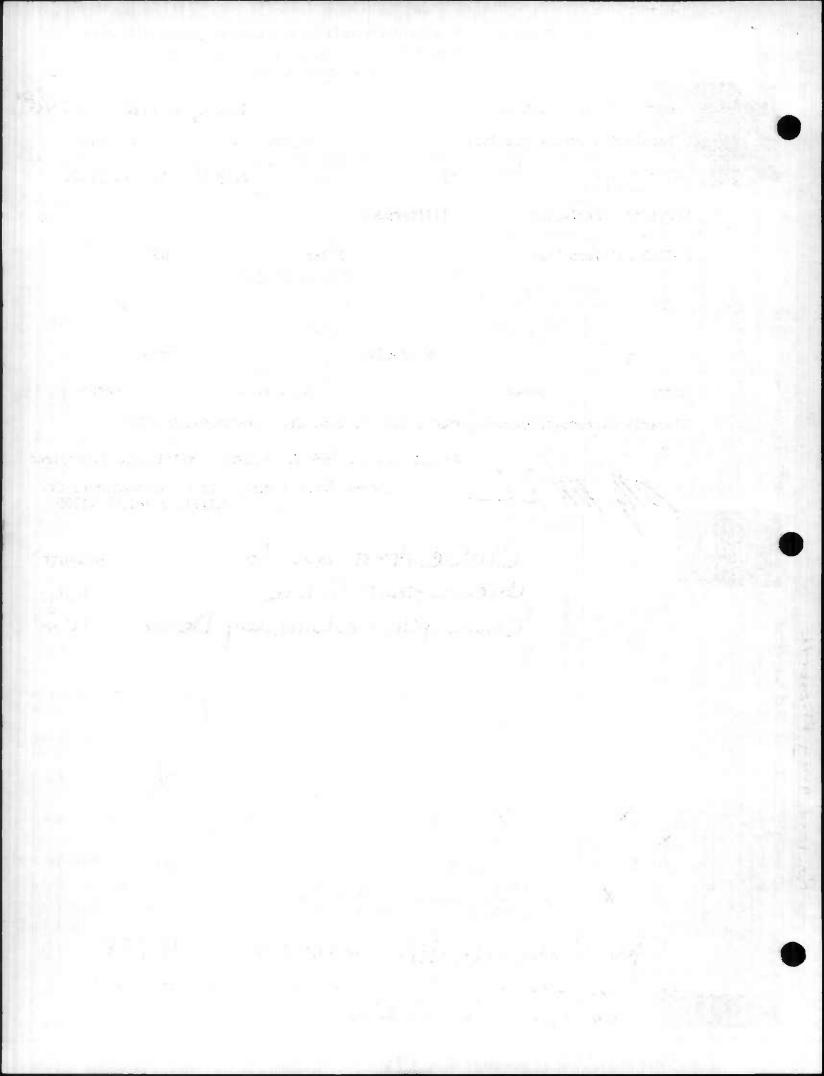
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Division of Vital Records,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3 Time of Death Month Patricia Ann REID 12:05 P.M. January 4, 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Deys Hours 217-28-5394 65 Yrs. Aug. 4, 1932 Maryland Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1K Yes 2 No Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19 West Maple Street 21734 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No if Yes. Give 1 ☐ Yes 2 ☒ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 12lead person state government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lawrence Grim Reid Rebekah Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia A. Reid/self Post Office Box 271, Funkstown, Maryland 20a Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State Jan. Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7,1998 21. Signature of Funeral Service Licensee 22. Name, and Address of Fecility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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r than "netural", or Items 23e or 28e-f show the Medical Evaminer must be notified at

death v

filed within 72 hours after

Hygiene.

Pages 1 end 2 should be filed an ent of Health and Mental Hygient: if Item 27 is marked other

permit. Pages 1 end 2 s
Department of Health ar
Important: if item 27 is
eny injury or other trau

Baltimore, Maryland 21215-0020

ettending physician end for use es the burial-tren

signed b

After this funeral

within 24 hours efter death.

To the Funerel Director: A completely filled in by the ft

Hospitai

To the

The law requires thet the death certificate be executed

Box 68760,

P.O. I

Records,

Division of Vital or Attending Physician.

Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of) Physician/Medical Examiner morrie Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of): to Childhood Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Vea 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: 1 papatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 Yes 2 No 27. Manner of Deeth Certification: 28e. Date of Injury (Month, Dev Year) 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated. Medical (Check only

29c. License number

Kel

29d. Date signed (Month, Dey, Yeer)

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Rec	ietra	•

196 Signature and title of certifier

KASS

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30 Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

medical

State of Maryland / Department of Health and Mental Hygiene 98 0 | 58

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Physic	ian	1. Decedent's Neme (First, Middle, L.								2. Dete of D		v , Y		3. Time of Dea
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Courth Month Physician GERRY ANN SMITH 0019 199 ann /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Month, Dey, Year) | May 14, 1939 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country).
Georgia **Funeral** 1 M 2 XF 215-36-6317 Yrs. 58 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Washington Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2X No Spacify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiena. Item 27 is marked other than " Elementery/Secondary (0-12) College (1-4or 5+) Manager Resturaunt 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumame) Be Paul C. Northcraft Margaret Elizabeth Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Thurman 1. Smith/ Husband 11 West Baltimore Street Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ter any injury or ott pnce. 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Zion Cemetery Jan. 16,1998 SanMar, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardie arrentto me Examiner Due to (or as a consequence of): Examine Protosth tanti Myocardial po mi Imparction physician end the buriel-transit be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): 68760 Physician/Medicai Due to (or as a consequence of): attending p 80 Box P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? tha 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dishts melliting Eld stag read direar Records, à 24b. Were autopsy findings availabla prior to completion of causa of death? Completed 24a. Was an autopsy Holytic's Lymphomo performad? certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 10 o this 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how Injury occurred or Attending 1 Natural 5 Pending Invastigation death. 1 ☐ Yes 2 ☐ No Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) n 24 hours after des ne Funeral Directo pletaly filled in by th 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) D18019 Jan 12, 1998 am such 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 42 334 mill Datte 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidson JAN 1 5 1998 Registrar

DHMH 16 Rev 6/95

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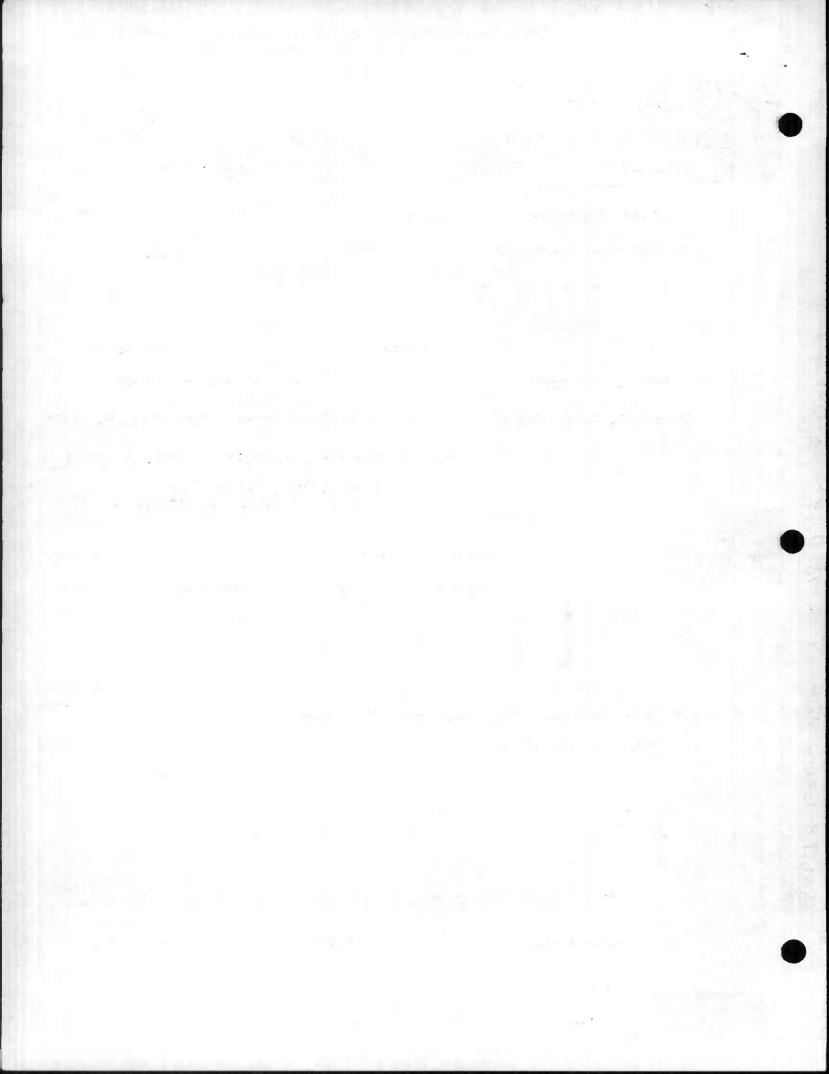
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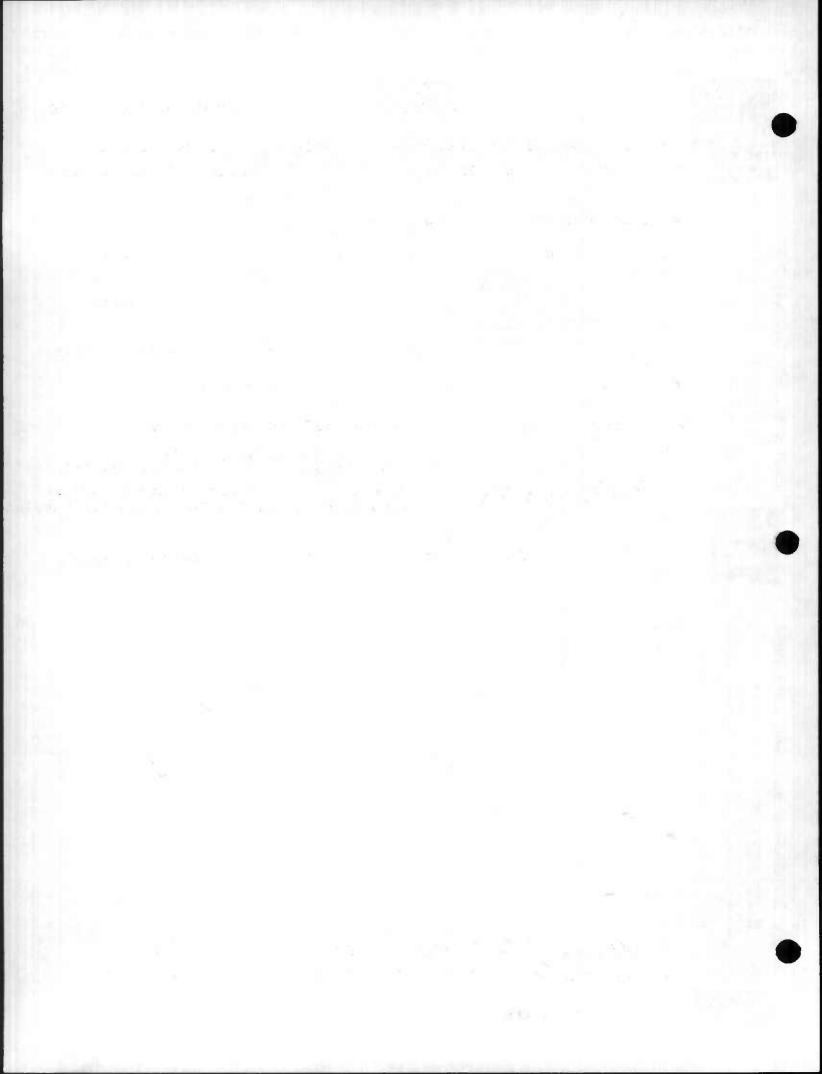
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** ROSA SWICKLAS JANUARY 8,1998 06:30a.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Calvert Memorial Hospital
5. Social Security Number 6. Sex 17 Anne II number Prince Frederick Calvert Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, March 9. Birthplece (State or Foreign 1921Maryland **Funeral** 10 M 20 F Months Deys Hours Min 76 215 18 6374 Yrs. Director Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner name be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 921 Ed Joy Road 20657 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 NX Specify: Specify white Completed by 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumetic event, the once. owner/ executive Hardware Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Edward Joy Almire Coster 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Louis Cirina - son P.O. Box 1537 Solomons,

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Date Md 20688 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Olivet Cemetery Jan 10 1998
22. Name end Address of Facility 4 ☐ Donetion 5 ☐ Other (Specify) Lusby, Cal Maryland 21. Signature of Funeral Service Licensee 20676 Rausch Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec shock, or heart failure. List only one ceuse on each line. Rd. Port Republic Marylan Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Pulmonery Discase Obstructive Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest pue the burial-trar Due to (or es e consequence of): P.O. Box 68760, the attending physician Physician/Medical Due to (or es e consequence of): deteched for Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by should be 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an eutopsy peen certificate has 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA After this in by the funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation **≯** Natural death. 1 Yes 2 No 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier TCC Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) end manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 047610 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. David J. Tardio, M.D., Prince Frederick, Maryland 20678 32. Registrac's Signature 31. Date filed (Month, Day, Year) State John Muchen Radall Registrar



State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Edna Mae 1998 January 13 8:30 p.m. 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death

7. Age (In yrs. lest birthday)

92

Yrs.

Hagerstown

10c. City, Town or Location

Smithsburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer)

Examiner _eFuneral

Director

Physician

/Medical

22006 Holiday Drive

10b. County

Washington

1□M 2√F

5. Social Security Number

10a. Stete

Maryland

10e. Street and Number

218-30-9419

Usual Residence of Decedent

r 28a-f show

	if the	Dire	10e. Street and Number		1	Of. Zip Coo	de	10	g. Citizen of \	What Country?
	23a	al	11944 Robinwood	Drive		217	42		USA	
020	72 hours efter death with the naturel; or ftems 23a or 21 pical Examine multibe na	by Funeral	11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,s Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Decedent s, specify (res 2	of Hispanic Origin? (S Cuban, Mexicen, Puer No Specify:	Specify Yes or No- to Rican, etc.)		ce - American Indian, ck, White, etc. White
15-0	"natural",	leted	15. Decedent's E (Specify only highest gr		16a. Decedent' (Give kind	S Usuel Oo of work do	ccupation one during most of wo stired)	orking 1	6b. Kind of Ba	usiness/Industry
21215-0020	d within 72 ho giene. r than "natui r e Medical	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	Homem.		tired)		Own H	Home
pu	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, II	Bec	17. Fether's Neme (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	alden Sumen	ne)
Maryland	should be nd Mental marked o	70	Charles W. Har	shman			La	ura E. Ga	iver	
Jar	2 she and and ls me		19a. Informent's Name/Relationship (Type, Print)			reet end Number or R			
	s 1 and of Health Item 27 other tr		Donald E. Smith		A					Maryland 21742
Baltimore,	Pages nent of ant: If It		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	ace of Disposition emetery, cremato ion U.Me	y or other	plece)			City or Town, State
Balt	permit. Pa Departmen Important: eny Injury once.		21. Signature of Funeral Service Lice	000	22. Na	me and A	dress of Fecility	504 M	ſain St	reet
	00 = 00		Latty K. A.	repette			Funeral H			MD 21773
	D100010100		23a. Pert1. Enter the diseese, or can shock, or heeft failure. List only	plicetions that caused the death one cause on each line.	. Do not enter th	e mode of	dying, such es cerdia	c or respiretory erre	st,	Approximate Intervel Between Onset and Deeth
	Physician /Medical		Immediate Cause (Finel	Arrite	Yvacas	15	ITS	1.		10 minest
	Examiner	1	disease or condition resulting in deeth)	e. Due to (or	es a consequen	VOIC	11 mil	erction		10 manue
L	₽ ≃	ner		Autorinalest	Te Comm	12.20	System de	COMP		15 years
	be executed sician and buriel-trensit	Examiner	Sequentially list conditions,	Due to (or	es e consequenc	e of):	TIVERY GI	TEAL		1 5 /car
60,	be exectan souriel-		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
68760,	physi s the l	g	that initiated events resulting in deeth) Lest	Due to (or	as e consequenc	e of):				
Box (ding	√Me		d						
Ä	atte	iciai	Pert II. Other eignificant conditions of	antsibuting to double but not record	hii-sh		nive is first to	DON DINA-		-6
P.0	that the ed by th deteche	by Physician/Medical	Total. Other digital continual	ommouting to death but not result	ung in the under	ying ceuse	given in Part I.		/	ntribute to the cause of deati
Vital Records,	law requires t as been sign 2 should be	Completed b						24e. Wes an perform	autopsy ed?	24b. Were autopsy findings avelleble prior to completion of cause of death?
Ä	0 - 0	mo.						1 ☐ Yes	2 NO	1 ☐ Yes 2 ☐ No
ita	Iclan: The certificate rector, pag	Be C	25. Wes cese referred to medical				26. Plece of De	ath (Check only one		1.1
of V	0 D	10	examiner? 1 ☐ Yes 2 ☐ No	Hospitai: 1 ☐ Inpatient 2 ☐ E	R/Outpetient 3	DOA	Other: 4 Nursing H	lome 5 ■ Residen	ocator	& Softet (Wina
	D 0 0	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury		njury at Work? I ☐ Yes 2 ☐ No	28d. Describe hov	v Injury occurr	red avea u
Division	or Atte	Certificatio	3 Suicide 6 Could not be determined	28e. Plece of Injury - At horn building, etc. (Specify)	me, farm, street, f	actory, offi	СӨ	28f. Location (Stre City or Town,	et end Numb Stete)	per or Rurel Route Number,
	To the Hospital or Attendin, within 24 hours efter death. To the Funeral Director: Att. completely filled in by the fun	edical C	29a. Certifier (Check only one) 12 Certifying Ph	ysician: To the best of my know niner: On the besis of examinetic and menner stated.	ledge, death occorn and/or investig	urred et the	e time, date and plece ny opinion, deeth occu	e, end due to the cau arred et the time, det	use(s) end me te and place, i	enner as steted.
	othin othin ompl	M M	29b. Signature and title of certifier	and monitor stated.		29c. Lic	ense number	296	d. Date signer	d (Month, Dey, Year)
	->-0		DRAR OO	MD Rangel Ph	Mois in	1	10425	a	To	14 100 C
,			30. Name end eddress of person who	completed ceuse of death (Item:	26e) (Type, Print		1233	tour	MI 7	17162
			31 Data filed (Month Day Year)	() / (010//4	we not	-	(onge !	1000h	ic /	VITA

20c. Locetion - City or Town, State yersville, Maryland Main Street sville, MD 21773 obacco use contribute to the cause of death? es 2000 3 Probably 4 Unknown 24b. Were autopsy findings avelleble prior to completion of cause of death? an autopsy med? 1 ☐ Yes 2 ☐ No avea treet end Number or Rurel Route Number, n, Stete)

Washington

August 4, 1905 Maryland

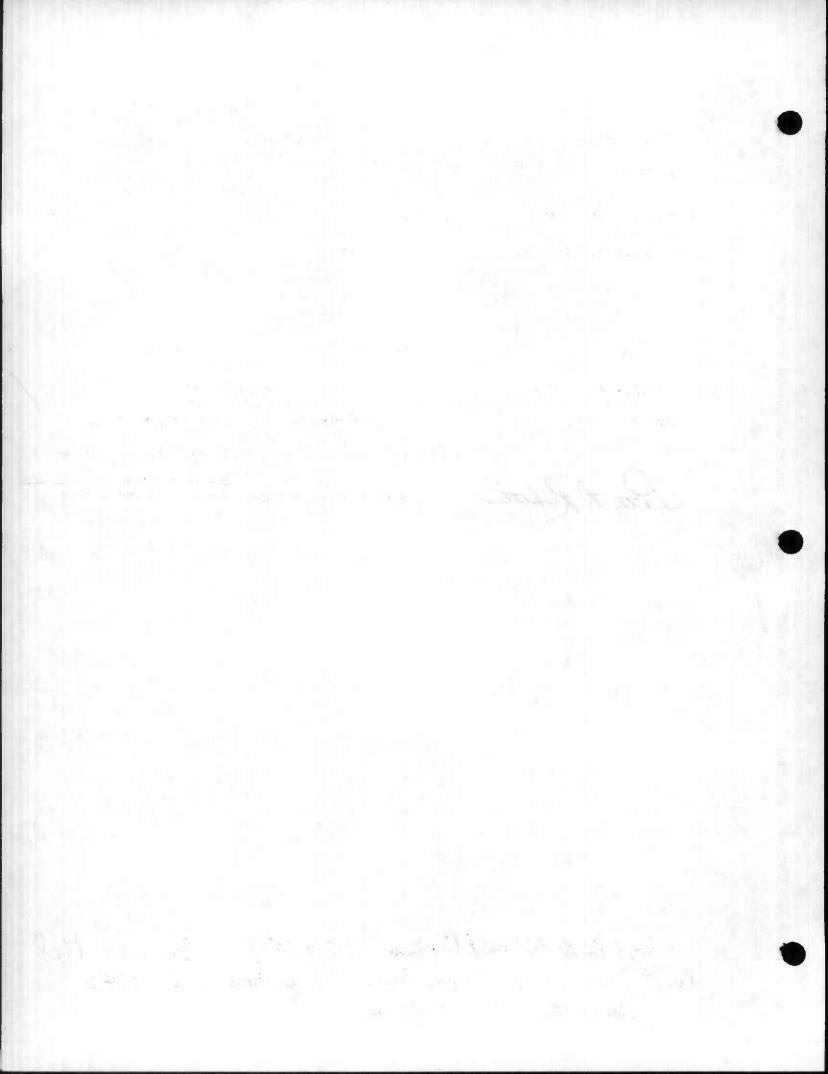
Birthplace (State or Foreign Country)

10d. inside City Limits

1 Yes 2 No

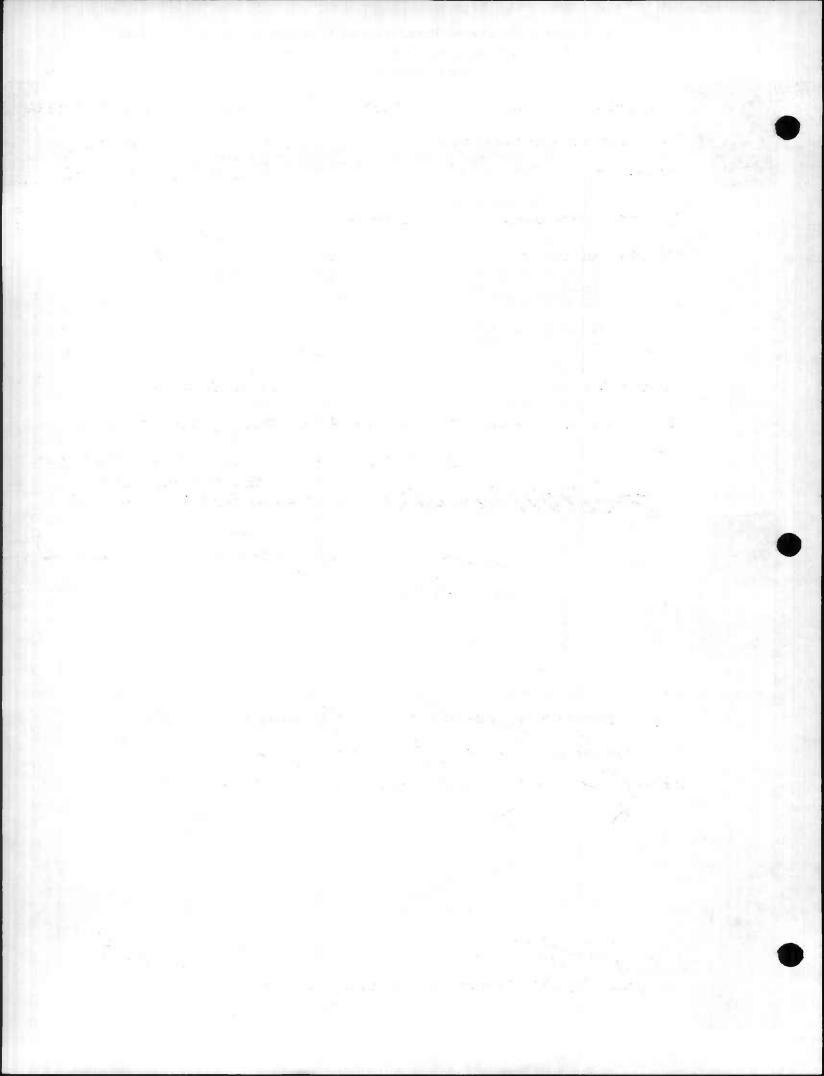
State Registrar 31. Date filed (Month, Day, Year)

JAN 1 5 1998



State of Maryland / Department of Health and Mental Hygiene 98 0 | 585

						Ce	rtificate	of Death		Reg.	No.	UI	202
			1. Decedant's Nama (First, Middla, L.	ast)	He sale	3113				a of Death			3. Time of Death
	ysicia Medic		MARGARET	Luc	ille	ST	OUFFER	2	JAI	NUARY		1998	12:35AN
	amin		4a. Fecility Nama (If not institution, gi	ve street and nu	m <i>ber</i>)			4b. City, Tov	vn, or Location of		4c. County of	-	
			Prince Georges H	ospital	Center			Chev	erlu		Prin	ce Ge	eorges
Fun	ieral		The second secon	Sax	7. Aga (In yrs. les	st birthday)	If Undar 1 Y		Min. 8. Dat	a of Birth	9		e (Steta or Foraign
Dire	ctor		579-14-2884	1□ M 2□20F	81	Yrs.	WOULDS D	ays Hours	Ap	a of Birth onth, Dey, Yai PLL 27	, 1916	Vi	rginia
Ъ.			Usual Rasidanca of Decedant										
aryla	THE T	_	10a. Stata 10b. County	4 7		Town or Lo						1	Insida City Limits
M Page	ATT .	cp	Maryland Anne	Arunde	6	Edge	ewater						1 □ Yas 2 □ No
₹ 20	N N	Director	10e. Street end Number				10f. Zip Co	da		10g.	Citizen of Wha	at Country	?
th w	Tin I	<u>a</u>	819 Selby Height	s Drive				21037			USA		
Q Z1Z13-UUZU filed within 72 hours after deeth with the Maryland thygiene. ther than "natural", or Items 23a or 28a-f show	or other traumatic event, the Madical Examines must be notified at	Funeral	11. Marital Status	12. Was Dec Armed Fo	edant Evar in U,S.	. 13.	Was Decedent	of Hispanic Orlg Cuban, Mexican	in? (Specify Ya	s or No-	14. Race -	Amarican Whita, atc.	
or affe	of or	田	1 Nevar Married 2 Marriad	1 ☐ Yes If Yas, Gi	2 11No		1 ☐ Yas 2 ☐		, r a a r n a n n	,	Specify:		
d within 72 hours aft giene. r then "netural", or	-	d by	3 Widowed 4 Divorced	Yeer or E			10 100 200	то орошу.			Specily.	whi	·te
72 h	gup	Completed	15. Decedant's E (Specify only highast gr	ducation		16a. Dece	dant's Usual O	ccupation ona during most atired)	of working	16b	. Kind of Busin	ass/Indust	try
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filed with Hygiene.	를	S	12	0			store m					her g	ooas
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should be nd Mentai	atic	2	George E. Downs	3					Margie	C. Te	ter		
2 she and and ls me	une.		19a. Informant's Name/Ralationship					reet and Numbe					
1 and Heelth Bm 27	ler tr		Harold R. Stouf	fer - hi				Heights	Dr., Ec	dgewat	er, Md.	. 210	37
Darillore, Permit. Pages 1 a Department of Hee mportant: If Item	to		20a. Mathod of Disposition 1 DBurial 2 Cremation 3 D	Domoual from	COL	ce of Disponatary, crar	osition (Name of matory or other	of r plece)	Date	20c.	Location - Cit	y or Town,	, Stata
Deficiency Department of I	o Au		4 □ Donation 5 □ Othar (Speci			e Hil	1 Ceme	teru	1-15-	.98 E	lagerst	own, 1	Maryland
permit. Department	any Injury		21. Signatura of Funaral Service Lice	nsea	24	T-12		ddrass of Facility			IERAL H	OME	
D ESE	any i		3-2	HYY)	1/10000	1/4	15 E W	ilson Bl					740
			23a. Partt. Entar tha disaase, or con	polications that of	caused the death					_			proximata
Dhania	io-		shock, or haart failure. List only	ona causa on a	aach lina.		1	7				Int	tarval Between
Physic /Med			Immediata Ceuse (Final		10-06	2	11.	//	/	*		10	1)
Exami			disease or condition resulting in death)	e	ereo	rad	in	yang	uco	2		u	celos
		i i			Due to (ogs	a consec	quence of):	1.4.					0
Pel	nsit	듣		b	mai	ore	na	un				V	Morour
A CO / CO, entificate be executed ding physician end	al-tra	Examiner	Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or injury thet initiated events		Dua to (or e	es a consec	quanca of):						
ficate be ex			Cause. Enter Undarlying Causa (Disaasa or injury	c									
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eath certif	for u	lan										1	
that the death ed by the atter	ped.	Physician	Part II. Other algnificant conditions	contributing to d	eath but not resulti	ing the u	ndarlying caus	a given in Part i.	23	b. Did tobec	co uae contri	bute to the	e causa of death?
hat the	deteched		Carona	20	arle	en	a	use	- 0	1 🗆 Yes	2000 3	☐ Probab	ly 4 Unknown
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of or Attending after death.	£ 6	Certification:	3 Suicida 6 Could not be datarminad	20a. Flaue	of Injury - At hom	ia, farm, str	aat, factory, of	fice			and Number	or Rural Re	outa Number,
व के व	<u>_</u>	e l	4 🗀 Homicida	buildi	ng, atc. (Specify)				City	y or Town, St	ata)		
spite			29a. Certifiar 1☐ CertifyIng Pt	nyaician: To tha	best of my knowle	edga, daath	n occurrad at th	na tima, data and	plece, and dua	to the cause	(s) and mann	er es stete	nd.
To the Hospital or within 24 hours after To the Funeral Dire	etel	edicai	(Check only 2 Medical Exer	minar: On the b	asis of examination nar stated.	n and/or in	vastigation, in	my opinion, daat	h occurred at th	a tima, date a	ind place, and	dua to the	a cause(s)
To the	dwo :	X	29b. Signatura and title of cartifiar	1			29c. Li	cansa number		29d. (Date signed /A	donth, Qay	(, Year)
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		-	mul you	ene			1	205	10	1	43/	170	7
			30. Name and address of person who				,	M2 60	205			(A) 1285	-10
			Dr. Catevenis, 3	OUI HOS	pital Dr	· s Ch	everly.	Ma. 20	185				
Ro	State distra		JAN 1	4 1998	legistrar's Signatur	Davids	on-Hande	02					
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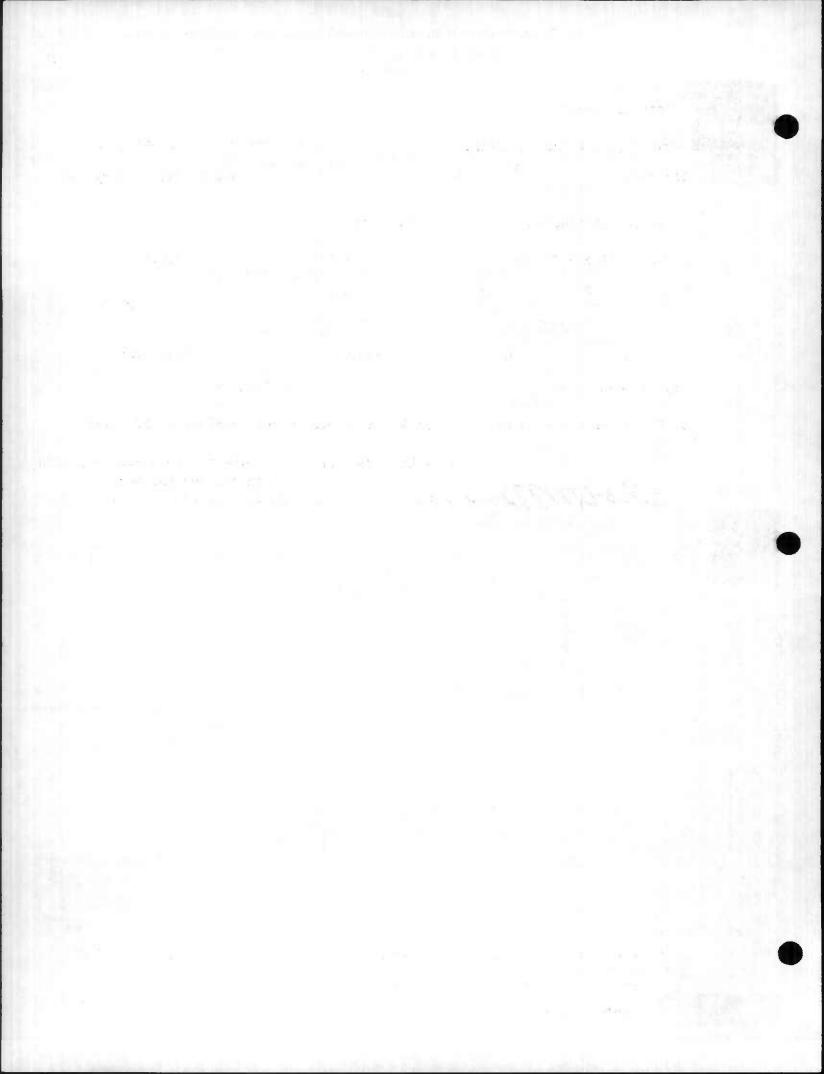
State of Maryland / Department of Health and Mental Hygiene 8 0 | 586

Physic					ate of Death		Reg. No.	
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/Medi	cal	EDNA 4e. Fecility Nama (If not institution,	Viola	SHU		or Location of Death		10 0. YS
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Pa-18	tor	Pa. Ad	ams	Bigle	erville			1 XYas 2□
yr 28	i e	10e. Street and Number		10f	Zip Coda		10g. Citizan of What	t Country?
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all a	Funeral Director	11. Marital Status	12. Was Dacedent Ever in U Armad Forces?	J,S. 13. Was D	ecedant of Hispanic Origin? specify Cuben, Maxican, Pu	(Specify Yas or No	- 14. Race - /	Amarican Indian,
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end s m		19a. Informant's Name/Ralationsh	p (Type, Print)	19b. Mailing Add	rass (Straat and Number or	Rural Routa Numbe	er, City or Town, Sta	ta, Zip Coda)
of Heal f Item 2 r other		Wilson W. Shultz 20a. Mathod of Disposition 1 ØBurlal 2 © Cremation	3 □Removal from Stata	167 Fast Placa of Disposition camatary, cramatory	York Street Bigl Nama of or othar placa)			
들은 등		4 Donation 5 Other (Sp	acify) Oak	Lawn Memor		01-13-98	Gettysburg,	Pa. 17325
Impor any ir		21. Signatura of Funaral Sarvica L.	1	Dazzi	a and Addrass of Facility			
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State of Maryland / Department of Health and Mental Hygiene 3

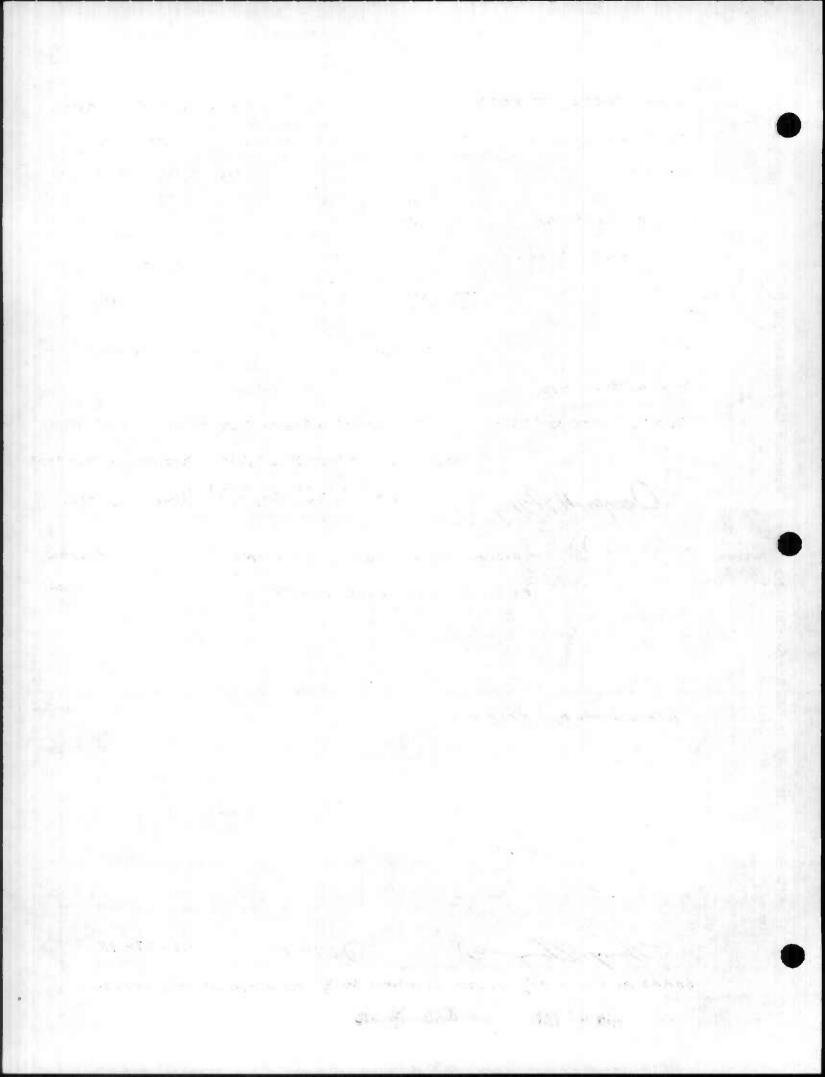
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Physician /Medical		Immediate Course /Final	\wedge		1		,	1	1			O1136(1	ond Death
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Attending or death. ector: After by the fune	atic	2 Accident invastigation		, , , , , , , ,	M]Yes 2□	No					
offer deat Director: I in by the	Certification:	3 Suicide 6 Could not to determined	286. Piece of in	jury - At home, fa	rm, street, fact	ory, office)	2	28f. Location (mber or Rura	I Route	Number,
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tho	Me	29b. Signature and title of certifiar	one marrier at	1	1 2	9c Licer	se number		- T	29d. Dete sign	ned (Month i	Day Va	ari
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		a Para I sale Ma			_	001	tificate of	Death		Reg. No.		
sician edicai	1	1. Decedent's Name (First, M. JOHN ALFOR		O STOUTAMYE	R				2. Dete of De Month January	Dev	98 ^{Yeer}	3. Time of Do
edica: iminer	•	4e. Fecility Name (If not institu						4b. City, Town,	or Location of Dear		ty of Death	
		17739 Burnsid	e Av	enue				Hagerst	cown	Wash	ingto	n
ral tor	2	5. Sociel Security Number 230–24–1906 Usual Residence of Decedent		9X № 2□ F 70	je (In yrs.	last birthday) Yrs.	If Under 1 Year Months Deys		lin. (Month, D	rth ey, Yeer) 21,1927	9. Birthr Cour Vir	olece (State or F ortn) ginia
	- 1-	10a. Stete 10b. Cou			10c. Cit	ty, Town or Loc	cation				1	I0d. Inside City I
ģ	I	Maryland Wash	ingt	on	Had	gerstow	m					1 □ Yes 2
i e		10e. Street end Number					10f. Zip Code	. 14		10g. Citizen of	Whet Cour	ntry?
aic	3	17739 Burnsid	e Av	enue			21740)		U.S.A		
To Be Completed by Funeral Director	2	11. Marital Stetus 1 ☐ Never Married 2 ☑ N 3 ☐ Widowed 4 ☐ Divord	-	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	1945	to46 1	Vas Decedent of Yes, specify Cub ☐ Yes 2 No		(Specify Yes or No erto Rican, etc.)	o- 14. Ra	eck, White,	etc.
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Be (3	17. Father's Name (First, Midd						18. Mother's I	Name (First, Middle	, Meiden Surna	me)	
P		rank A. Stout	amye	r				Mae S	mith			
		19e. Informent's Neme/Relation				19b. Meiling	g Address (Stree	t e <i>nd N</i> um <i>ber</i> or	Rurel Route Numb	er, City or Town	n, Stete, Zip	Code)
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once.		21. Signature of Funeral Servi	NS	Zin.		D. 1.	Name end Addr Ouglas <i>P</i> 331 East	. Fiery	Funeral	Home gerstown	n.Md.	21742
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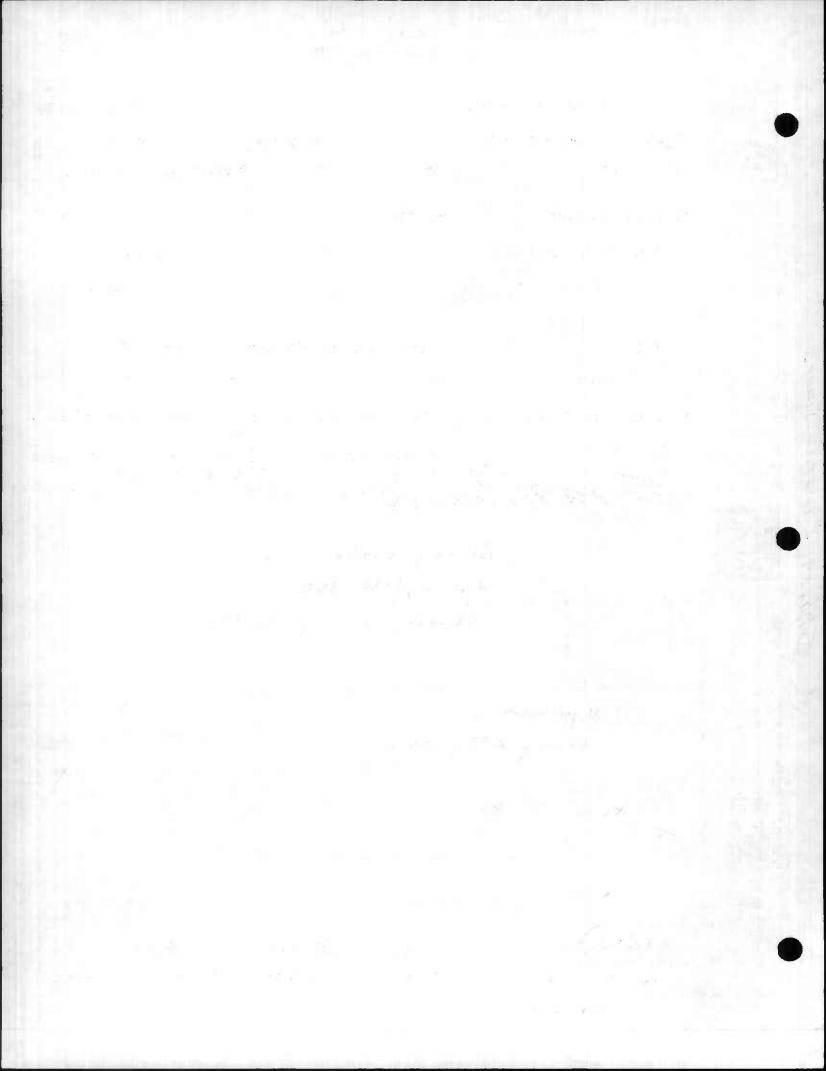


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 8 1 5 8 9

					erillica	te of	Death			Reg. No.		
		1. Decedent's Name (First, Middle, L	ast)	DOM:				2	2. Dete of De	ath	V	3. Time of De
Physicia /Medic	_	Edward J	ames SHAR	ON					Month Janua	Day	1998	093
Examin		4e. Facility Name (If not institution, g	va straat and number)				4b. City, To		ation of Death		inty of Deeth	
		Washington Count	y Hospital				Hagers	stown		Was	hingto	n
uneral			Sex 7. Age 1. M 2□ F	(In yrs. last birth	Months	or 1 Year Deys	if Under Hours	Min.	B. Date of Bird (Month, Pa November	h y, Year)	9. Birthp	lace (State or F
		Usual Residence of Decedent				1				1934		/
how		10a. State 10b. County		10c. City, Town							1	0d. Inside City I
or 28a-f show	5	Maryland Washing	gton	Hagers	town							1 ☐ Yes 22
	Director	10e. Street end Number			10f. Z	ip Code				10g. Citizen	of What Coun	try?
		10838 Oak Fores	st Drive			217	40			U.S	S.A.	
0 5	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give 19 Year or Dates:	ver In U,S. 956-	13. Was Dec If Yes, sp 1 \(\text{Yes}		Hispanic Ori ean, Mexicar Spacity:		ify Yes or No can, etc.)		Race - Americ Bleck, White, ecify: Wh	
"natural", adical Exp		15. Decedent's E	ducation		ecedent's Us	uel Occu	pation			16b. Kind o	of Business/Inc	fustry
	Be Completed	(Spacify only highast gi	ade complated) College (1-4or 5-	()	ecedent's Us Giva kind of w ifa. DO NOT	ork dona usa ratire	during mos	t of working	7			
	E	Elementary/Secondary (0-12) 0-12	College (1-4or 54	pr	oducti	on c	oordin	nator		truc	k mfg.	
d othe	eC	17. Fether's Neme (First, Middla, Las	t)				18. Mothe	er's Neme (First, Middle,	Maidan Sur	name)	
	ToB	Edward		Sharon				M	ary An	n Coll	pert	
aumatic event, the M	-	19a. Informant's Name/Relationship	(Typa, Print)	19b. N	Mailing Addres	s (Straa	t and Numbe	er or Rural	Routa Numba	ar. City or To	wn. Stata. Zip	Coda)
27 le or tra		Mrs. Joann E. Sha			17-							and 214
Edi	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Plece of D cematary,	isposition (Ni crematory or	ame of othar pla	ice)		Date		on - City or To	
ant		4 Donetion 5 Other (Special	(ty)	Rest H	aven C	emet	ery	6,	1998	Hager	stown,	Maryla
important: If it eny injury or once.		21. Signature of Euneral Service Lice	nsee	enne d	//		ess of Facilit Vilson				ral Hon wn, Mar	ne yland :
		23a. Part1. Enter the disease, or con shock, or heart feilure. List only	plications that ceused t	the deeth. Do no	t enter the mo	de of dy	ng, such es	cardiac or	respiratory a	rest.		Approximate
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byt	by Physician	Hype	tensur						10	Yes 2 N	lo 3 Prot	pably 4 □ Un
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his certificata has been signe il director, page 2 should be c	To Be	25. Wes case referred to medicel examiner? 1 ☐ Yes 2 → to 27. Manner of Death	Hospital: 1 Impatien	28b. Tin	atient 3□ D	UA	ner: 4□ Nu	rsing Home	Check only o	na)	Other (Specify	
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DHMH 16 Rev 6/95



BALTIMORE, MARYLAND 21215-0020

6

7	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATN					
	Evelyn Alberta Sibley								Jan 5, 1998			TEAN	12:05 p M	
RECTOR	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (in yrs. las	(In yrs. last birthday) IF U		1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
	293-12-4582		1 M 2 XF	75			DATS	HOURS MIN.		Apr 6, 19				
	9e. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCA		OR LOCATION OF D				9c. COUNTY OF DEATH			
	Allegany County Nursing Home					Cumberland Allegany							ny	
	10e. STATE 10b. COUNTY				10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?	
0	MD Allegany				Cumberland								1 X YES 2 NO	
COMPLETED BY FUNERAL DIRECTOR	10e. STREET AND NUMBER					101. ZIP CODE				10g. CITIZEN			WHAT COUNTRY?	
	36 Browning Street					21502								
	11. MARITAL STATUS	NT EVER IN U.S. AR	ARMED 13. WAS DECENDENT OF HIS XNO If yes, specify, Cuben, Me								E — Americen Indien, k, White, etc.			
	1 Never Merried 2 X Merried IF YES, GIVE WAR OR DATES 1 Never Merried 2 X Merried IF YES, GIVE WAR OR DATES					1 TES 2 NO Spe			ify:			Spec	ify:	
	15. DECEDENT'S EDUCATION 18e. O					DECEDENT'S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUST			White	
	(Specify only highest grade completed)			(G	(Give kind of work done during most of working life. Do NOT use retired.)				160. KIND OF BUSINESS/INDUST			DUSTRY		
PL	Elementery/Secondary (0-12) College (1-4 or 5+)								0 17					
TO BE COM	17. FATNER'S NAME (First, Middle, Last)				omemaker 18. MOTHER'S NA				Own Home ME (First, Middle, Maiden Surname)					
	John Carter				-76									
						Mary (nmn) MAILING AODRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)								
	Paul Sibley-husband				36 Browning Street Cumberland MD 21502)	
	200. METNOO OF DISPOSITION 20b. PLACE AND DATE OF DISP													
	1 M Buriel 2 ☐ Cremetion 3 ☐ Removal from State cemetery, crem					amatory or other place) awn Memorial Gardens 01/08 LaVale MD								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF F								ACILITY					
	Scarpelli Funeral Home, P.A.													
	23. PART/I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate													
MEDICAL CERTIFICATION	ahock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CORDPACT ARTENY DISEASE OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate control of the conditions of the con													
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST oue to (or as a consequence of): d													
	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given											24b	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
음	MITRAL VALVOLAR DISEASE CHRONIC OBSTRUCTIVE LUNG DISEASE								1 TES 2 TY NO				COMPLETION OF CAUSE OF DEATH?	
ME	CHEONIC OBSTRUCTIVE LUNG						01:	SEASE					1 TYES 2 TAO	
ż	DID TOBACC	O USE	CONTRIBUT	TE TO CAU	ISE O	F DEA	TH	YES N	O 图					
S	25. WAS CASE REFERREO TO MEDICAL EYAMINER? 26. PLACE OF DEATH (Check only one)													
S	1 TES 2 NO			ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Residence	6 Other (S	(pecify)				
Y PHYSICIAN:	27. MANNER OF CEATN 1 A Naturel 5 Pending (Month, Day, Year) 2 Accident Investigation					28b. TIME OF INJURY AT WORK? M 1 YES 2 NO				28d. OEŞCRIBE HOW INJURY OCCURED				
ED BY	- Pacidelli					ome, ferm, street, fectory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	(Check only													
	29b. SIGNATURE INO TITLE OF CERTIFIER						29c. LICENSE NU			MBER 29d. DATE SIG			(Month, Day, Year)	
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM					D- 14						5,1998		
	Dr. Robus	Dr. Robustiano Barrera Memorial Hospital Medical Bldg. Cumberland MD 21502												
	31. DAN () 9 199	18		AR'S SIGNATURE										

		1. Decedent's Nema (First,	Middle, Las	it)		Ce				2. Dete of De			3. Time of Deeth
Physic		Mildred	Ioi	na	Tibb	S				Januar Januar	Day	Yeer 998	12:45 PM
/Med Exam		4a. Fecility Neme (If not Inst	itution, give	straet end nu	mbar)				4b. City, Town, or			y of Death	12.45 111
		6215 Macka	L1 Roa	ad					St. Leo	nard		Calve	rt
Funera Directo		5. Social Sacurity Number 220-32-6088		ax □M 2∏ F	7. Age (In yr	s. last birthday, 74 Yrs.	Months	Days	If Under 24 Hrs Hours Min		rth ey, Year) , 1923	9. Birthp Coun Mar	lace (Steta or Foreign try) yland
and		Usual Rasidenca of Deceder 10e. Stete 10b. Ce			10c. C	ity, Town or L	ocation					1	Od. inside City Limits
Meryl f ehc	to	Maryland	Calve	ct		St	. Le	onard	1				1 ☐ Yes 2 ☐XNo
h the	Director	10e. Street and Number					10f. Z	p Code			10g. Citizen of	What Coun	itry?
th wit	a D	6215 Macka	11 R	oad				2068	85		J	JSA	
be filed within 72 hours efter death with the Meryland nel Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Divi		12. Was Dec Armed Fo 1 Tas If Yes, Gi Yeer or D	2 K No	U,S. 13.	Was Dece If Yes, spo 1 Yes		lispanic Origin? (an, Mexican, Pue Specify:	Specify Yas or Norto Rican, etc.)		14. Raca - Amarican Indien, Bleck, White, atc. Specify: Black	
72 ho	Completed	15. Dec	edent's Ed	ucation de completed)		16e. Dece	Se. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus						dustry
Men.	mpidu	Elementary/Secondery (0		College (DO NOT		d)	, and	Otem	Home	
707		12 17. Fether's Neme (First, Mi	ddla Lasti				iouse	wile	19 Mother's No	me (First, Middle			
should be filed and Mentel Hygi marked other imatic event, it	Be	Orville	T.	Но	we				Iona	inte (First, ivilouie		Vallac	e
s 1 and 2 should be file f Heelth and Mantel Hy fam 27 is marked other other traumatic event.	5	19a, informent's Neme/Rele	tionship (7	vpe, Print)		19b. Mail	ing Addres	s (Street	end Number or F	iural Route Numb	er. City or Town	n. State. Zip	Code)
CENL	15	Bernadette Gross/Daughter 6215 Mackall Road St							. Leonar				
of Her of Her f Item	ю	20a. Method of Disposition 1							ce)	Dete	20c. Location	- City or To	wn, Stata
Peges nent of } ant: If its		4 Donetion 5 Oth			State	rooks I				1/10/98	St. Lec	nard,	MD
permit. Peges 1 er Department of Hee Important: If Item; any injury or othe		21. Signetura of Funerei Se	q.	Sevel	0								MD 20678
		Sewell Funeral Home Sewell Funeral Home											
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/Medical Examiner	_	immediate Ceuse (Fine) disease or condition resulting in death) a. WEASTANC PANSQUANC CARCUMMA EVERAL Due to (or as a consequence of):											SHEARS
	1.0				Due to	(or as a conse	quence of):					
uted	Examiner	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events reculting in death) I set											
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the elf	Physician/M	Part ii. Other significant con	nditions co	ntributing to de	eath but not re	sulting In tha	ınderlying	cause giv	en in Part i.	23b. Dfd	tobacco use c	ontribute to	the cause of death?
res that the designed by the electron of the deteched for										10	Yes 2 No	3 Prot	sably 4 Unknown
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hes b	npldu	- N											deeth?
: The lacate he										10	Yes 20 No	10	Yes 2000
Physician: The this certificate	o Be	25. Wes case referred to me examiner?	-	Hospitel:				Oth	Ar	eth (Check only			
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of or Attending saftar death. I Director: After In by the fune	Certification:	3 Suicide 6 □ C	ould not be etermined	28e. Placa buildi	of fnjury - At ling, etc. (Spec	nome, farm, st			700 2.3110	28f. Location (City or To		ber or Rura	l Route Number,
Hospital 4 hours Funeral taly filled	edical Ce	(Check only 2 Med	tifying Phy	iner: On the bi	asis of examin	owledge, deat etion and/or in	h occurred	et the tim	ne, date and piec pinlon, deeth occ	a, end due to the	cause(s) and m	enner es st	eted.
To the Vithin 2 To the Complei	Med	29b. Signeture end title of ce	Λ.	end mani	ner stated.			c. Licens			29d. Date sign		
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1	1	xeter water D16364									1 1 20	1 7	
10		30. Name and address of ne	rson who o	ompleted caus	a chrieath /ite	m 23a) (Turce	Print\	U	030		110	10	
10		30. Name and eddress of pe Peter R. Gr						Rd.	Ste. 300) Annap	olis, M	D 2140	01

The Table 1 * ^ 7 - 1 00 1-1,0. the second times With a resident of the south power to the

Gelk,

30 Nama and addrass of person who completed causa of daath (Itam 23a) (Typa, Print)

Registra

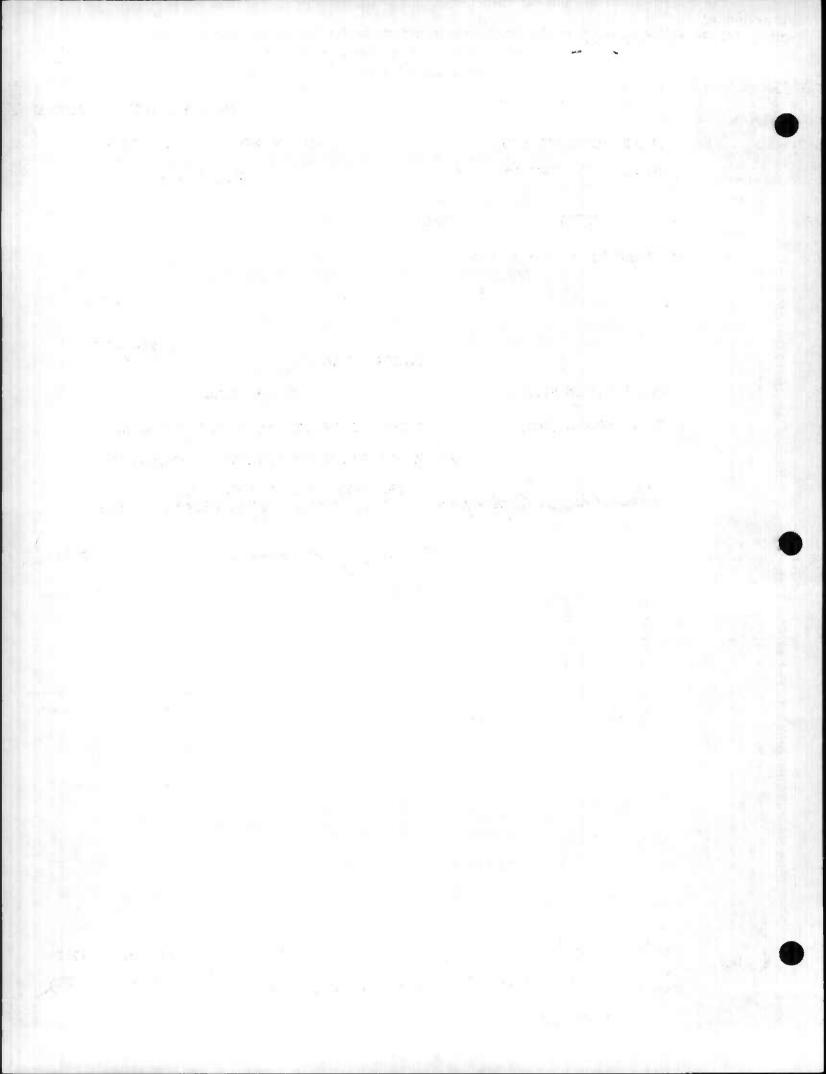
State

31. Data filed (Month, Day, Year) JAN 08 902 Seton

32. Ragistrar's Signatura

010

29d. Date signed (Month, Dev. Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death Month **Physician** 1998 January 5.20pm GRACE LORETTA /Medical TRAIL 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LIONS MANOR NURSING HOME CUMBERLAND ar If Undar 24 Hrs. ALLEGANY 8. Data of Birth (Month, Day, Year) AUG 14 1927 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Birthpleca (Stata or Foraign Country)
 W . VA . **Funeral** Months Hours 10 M 20 F Days Min 212-24-0002 70 Yrs Director Usual Residence of Decadent the Maryland 10a. Stata 10b. County 10c. City. Town or Location or 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Director 1 ☐ Yas 2 ☐ No MARYLAND ALLEGANY FLINTSTONE 10e. Straet end Number 10f. Zin Code 10g. Citizan of What Country? 13510 GLENDALE FARM ROAD 21530 itams 23a U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours aftar daath \\
Department of Health and Mental Hygiene.\\
Important: If fem 27 is marked other than "natural", or itams 23\\
any Injury or other fraumatic event, the Medical Eventher main . Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc 1 Nevar Marriad 2 Marriad 1 ☐ Yas 2 🗹 No If Yas, Giva Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yas XX No Specify: þ 3 X Widowad 4 □ Divorced Yaar or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) HOUSE KEEPER HOUSE KEEPER 17. Fathar's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Surname) Be CHARLES HARPER EDITH HIGGS ပ 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) DAVID F. TRAIL 13500 GLENDALE FARM ROAD FLINTSTONE MD. 21530 SON 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata PINEY PLAINS METH. CEMETERY JAN 9 1998 LITTLE ORLEANS MD. 4 ☐ Donation 5 ☐ Othar (Spacify) Tature of Funaral Sarvica Licansaa 22. Nama and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND anter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Entar tha disaasa, or complice shock, or haart failure. List only on s that causad tha daath. Do not anta Approximata Intarval Batween Onsat and Death Physician Immadiata Causa (Final diseasa or condition rasulting in daath) /Medical 3da heuns ration Examiner Dua to (or as a consaquance of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immadiata ceusa. Entar Underlying Ceusa (Disaasa or injury that initleted avents rasulting in daath) Last Dua to (or es a consequance of): Division of Vital Records, P.O. Box 68760. attanding physician for use as the buria Physician/Medical Dua to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the causa of death? signed by 3 Probably 4 Unknown 1 Yes 2 No disease by 24a. Was an autopsy 24b. Wara autopsy findings available prior to Completed been complation of causa of death? certificata Hospital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: ^oL 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) After this within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicida 12 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and plece, and dua to the cause(s) end mannar as stated.
2 Medicat Examinar: On the best of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, end dua to the cause(s) and mannar stated. Medical 29a, Certifier (Check only one) the 29b. Signatura and titla of cedifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 4 an

Lions Manor Nursing Home, Seton Drive Extension,

Cumberland MD 21502

State Registrar

UKC

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

32 Ragistrar s Signatura

Y. A. Kanji than M. 31. Data filed (Month, Day, Yark)

Haall & short

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Jan 4, 1998 2:29 pm Mary Ellen True 4a. Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Daath 4c. County of Death 1308 Oldtown Road Allegany Cumberland 5. Social Sacurity Number If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Feb 3, Birthplace (State or Foreign Country) MD 7. Aga (In yrs. last birthday) Days 1 M 20 F Yrs. 70 212-24-2477 Usual Rasidanca of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits N Yas 2 No Cumberland Allegany 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1308 Oldtown Road USA 21502 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacadant Evar In U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, etc. 1 ☐ Yas 2€ No If Yas, Giva Yeer or Datas: 1 □ Never Married 2 □ Married 1 Yas X No Specify: Specify 3€ Widowad 4 Divorced white 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Retired Office Mgr. General Graphics 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Dennis H. Springer Lillian (Day) 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1308 Oldtown Road Cumberland MD 21502 Charles E. True-son 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ₺ Burlal 2 □ Cremation 3 □ Removel from State Rocky Gap Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) Flintstone MD 01/07 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immadiata Cause (Finel disaasa or condition rasulting In daath) a. Ca of the colon with diffuse Dua to (or as a consequence of): metastasis to lungs Dua to (or as e consequence of): Dua to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were eutopsy findings aveileble prior to completion of causa of daath? 1 ☐ Yes

Physician /Medical Examiner

physician and s the burial-transit

as the attending | use : for

signed by

peed has

certificete

After this

To the Hospital or Attending i within 24 hours effar death. To the Funeral Director: After

funeral director,

the

filled in by

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certificate be executed

Box 68760

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

State Registrar MD

Funeral

Director

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permit. Peges 1 end 2 should be filed within 72 hours aftar death with the Marylen Depertment of Haeith and Mentel Hygiene.
Important: If tem 27 is marked other than "natural; or itams 23a or 28a-f show eny injury or other traumatic event, the Mosca Examinat mant has not lifed any injury or other traumatic event, the Mosca Examinat mant has not lifed any injury or other traumatic event, the Mosca Examination.

3altimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Diseese or Injury that initiated avants rasulting in death) Lesf

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 28. Piece of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

25. Was casa referred to medical axaminar? 1 Yas 2 No 27. Mennar of Death 5 Panding 1 Natural

28a. Data of Injury (Month, Day Year) invastigation 6 Could not be datarmined

28b. Tima of

28c. Injury af Work? 1 ☐ Yas 2 ☐ No Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifian (Check only one)

2 Accidant

4 Homicida

3 ☐ Suicida

12 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifian

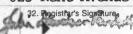
29c. Licansa number D 23371

29d. Data signed (Month, Day, Year)

TUS

30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print)

625 Kent Avenue Cumberland MD 21502 Dr. Qamar Zaman



The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alfred Marshall Ward January 1998 11:10 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Sept 22 If Under 1 Year Months Days 5. Social Security Number 6 Sax 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□ F Months 578 03 3450 85 1912 WashingtonDC Director Usual Residence of Decedent with the Maryland works / 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23s or 28s-f shot traumatic event, the Medical Exactions must be multipled at 1 ☐ Yes 2 ☐ No Director Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1035 Ball Road 20685 United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. hours after TX Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: white à 3√2 Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filled withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, In Manuary injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 8 assitant air conditioning steamfiiter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 Burton Ward Effie Chaney 19a, Informent's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Ellen Fischer- daughter P.O. Box 273 St. Leonard Maryland 20685
Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other piece) ™Surial 2 ☐ Cremation 3 ☐ Removel from State Maryland Veterans Cemetery Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Rausch Funeral Home 4405 Broomes Is. Rd. PortRepublic Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate thtervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner DURAL Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury ettending physician end for use es the burial-tran Due to (or es e consequence of) Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by þ pe page 2 should 24b. Were autopsy findings eveileble prior to Completed 24a. Was en autopsy performed? peeu completion of cause of death? certificate hes Shision of Vital R 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Hapatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury death. 1 Yes 2 No To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

29c. License number

PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636

29d. Date signed (Month, Dey, Yeer)

State Registrar 29b. Signature and title,

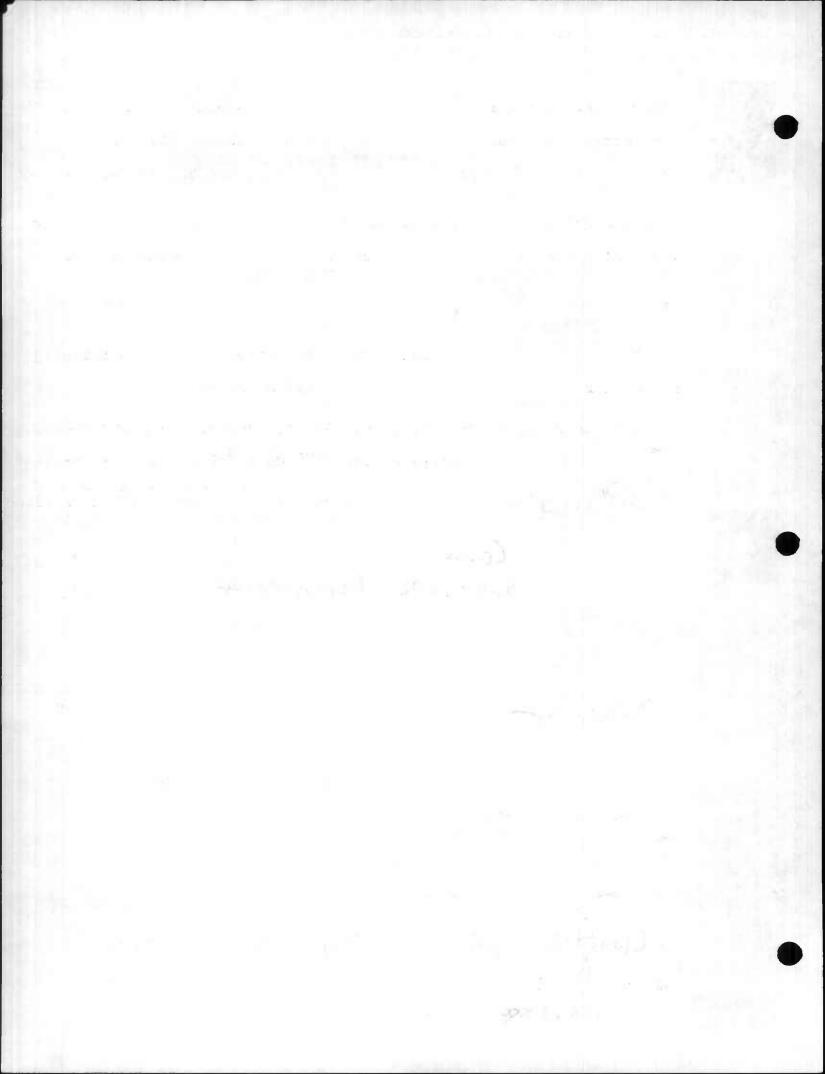
ANIL K. SHAH M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature.

Substitute of the Standard Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** 7:40 PM **JANUARY** 12 1998 BERNICE MAY WOLFE /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FAHRNEY-KEEDY HOME AND VILLAGE BOONSBORO WASHINGTON Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Yrs. MARCH 17, 1913 Director 212-24-5126 84 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examinar reset be notified at 1 ☐ Yes 2X No Director MARYLAND WASHINGTON **BOONSBORO** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21713 U.S.A. 8507 MAPLEVILLE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 12 should be fi end Mental H Is marked of 2 GEORGE H. FORD BLANCHE L. ITNYRE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 sh Department of Health end Important: If itsm 27 Is n any Injury or other traun FRANCES L. EVERLINE/SISTER 8507 BARNES ROAD, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/15/98 BOONSBORO CEMETERY BOONSBORO, MARYLAND 21. Signature of Funeral Service Livensee 22. Name end Address of Fecility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical vwoprus 1 dy **Examiner** Due to (or es e consequence of): Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequenca ot) exe eq P.O. Box 68760. Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the à 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed peen performed page 2 1 Yes 2 No ete 1 □ Yes 2 □ No Division of Vital certific Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pt within 24 hours after death.

To the Funaral Director: After it completely filled in by the funera 27. Menner of Death Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. Medical (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) and menner stated. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Jan 13, 1998 Vs. Te 140) 218019

334 Mill Street, Hagerstown, MD

21740

State Registrar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JAN 1 4 1998

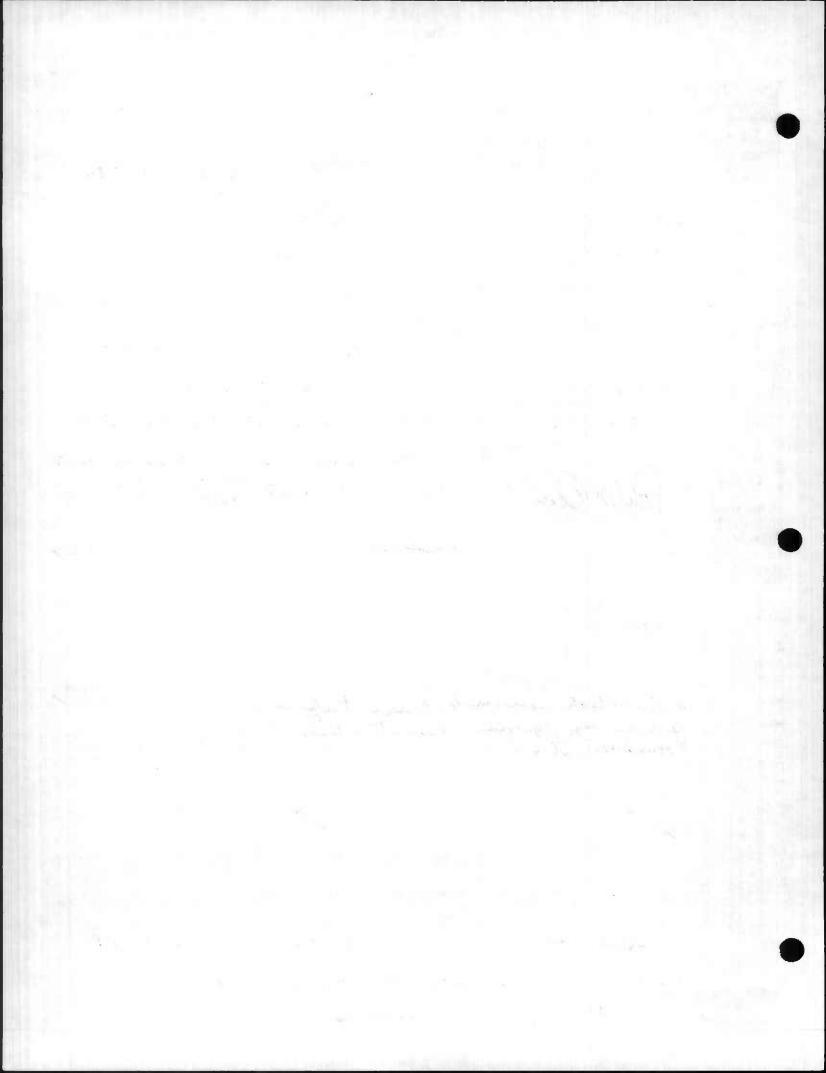
32. Registrar Signature

4 Was Davidson

DR. VASANT DATTA

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Q Month **Physician** Lee Hilliard WOLF muan /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Logation of Death 4c. County of Deeth **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 11X M 2□ F 77 Yrs. Director 212-14-6751 Sept. 27,1920 Maryland Usual Residence of Deceden 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 920 Mt. Aetna Road USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes:1942-45 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2X No Specify: by Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) auto repair auto mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Marie Greenwalt 0 Henry Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2. Depertment of Health et Important: If Item 27 is any injury or other traa 920 Mt. Aetna Rd., Hagerstown, Md. 21740 Virginia A. Wolf - wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 1-12-98 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel Dow eumono disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 Yes 2 ₽No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

Physician /Medical Examiner The law requires that the death certificate be executed buriel-trans Box 68760. attending physician for use as the burie use as Division of Vital Records, P.O. signed by t certificate has or Attending Physicien: After this s efter deeth. in by t within 24 hours e To the Funeral C completely filled Hospital the

the Maryland

72 hours after

Maryland 21215-0020

Baltimore,

Lec

28a-f show

or items 23e or

traumatic event, the Medical Examiner must be notified at

nd Mentel Hygiene. marked other than "netural",

end l

Pages 1 and 2 should be nent of Health and Mentel

Medical

29a, Certifier

State Registrar 31. Dete filed (Month, Day, Year) JAN 1 2 1998

29b. Signeture and title of certifier

29c. License number

1 critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

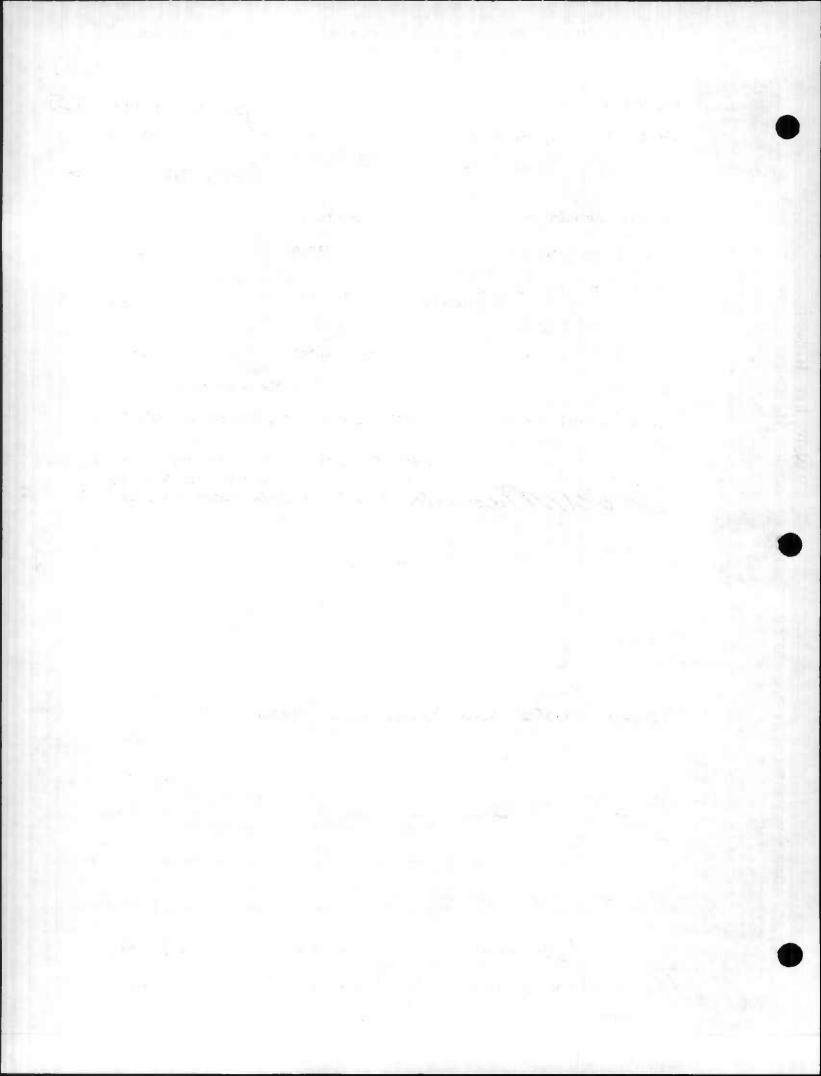
29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

WALKED up - 12821- OAK HILL AVE. HAGERSTOWN- MD BOUL

32. Registrar's Signature

Fulia Davidson

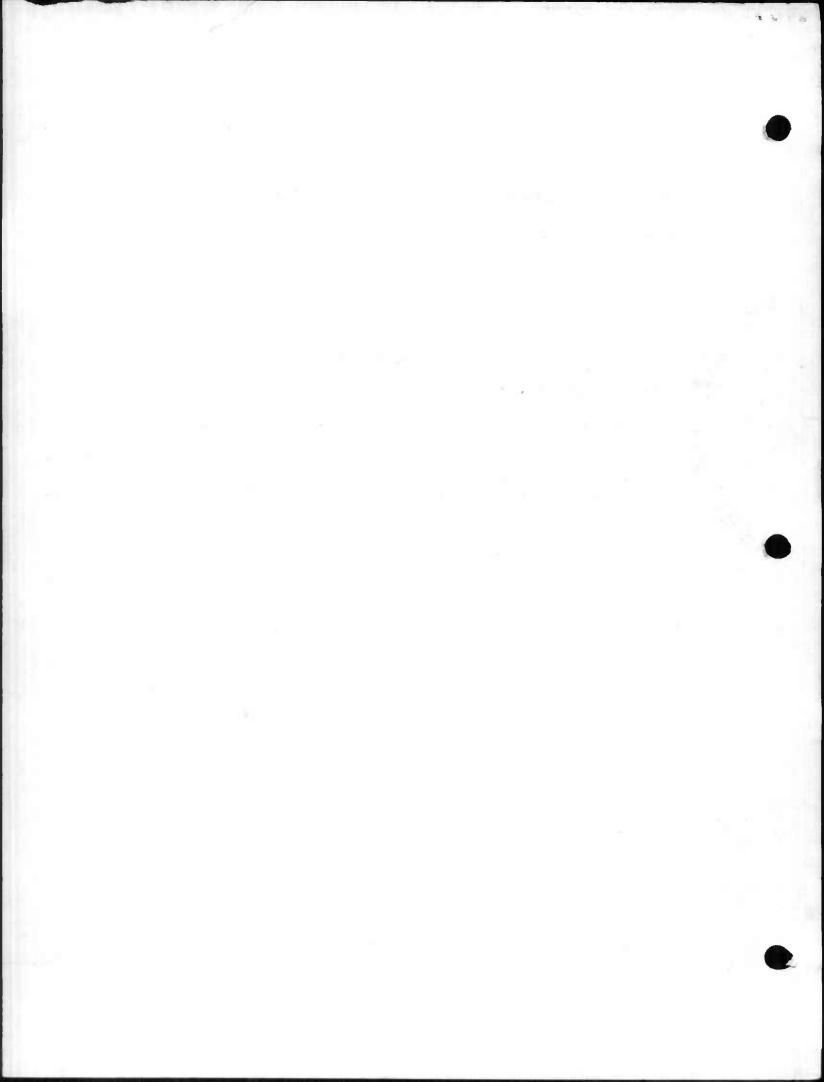


BALTIMORE, MARYLAND 21215-0020

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01598 98 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

											HEG. NO.			
ŀ	1. DECEDENT'S NAME (First,	, Middle, Last)								2. DATE O	F OEATH		YEAR	3. TIME OF OEATH
	George Lu	ther	Waters							Janua			98	12:50 Pm
- 1	4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE O				IPLACE (State or Foreign
	045 40 000		1 XXM 2 □ F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)		Count	(γ)
	215-18-288	38	1 ALM 2 L F	74	Tho.	Tho.				July	30, 1	923	923 Maryland	
	9a. FACILITY NAME (If not in	Sa. FACILITY NAME (If not institution, give street and number)								EATH 9c. COUNTY O			NTY OF E	EATH
7	Clearview N	Clearview Nursing Home							town			la	lach i	ington
BY FUNERAL DIRECTOR	RESIDENCE OF DEC	RESIDENCE OF DECEDENT							TOWIT			V	asiii	riigion
	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
														LIMITS?
ا د	Maryland	Wash	nington			Sr		sbur						1 X YES 2 NO
4	10e. STREET AND NUMBER						10	of. ZIP COD	E			10g. CITI	ZEN OF	WHAT COUNTRY?
	308 W. Mai	in Stre	et					2	1782				USA	4
Z	11. MARITAL STATUS	11 011 0	12. WAS DECEDEN	IT EVER IN U.S. A	PMED	13	WAS DE			NIC OBIGINS	(Specify Yes	or No.		E — American Indian,
	1 Never Married 2	Married	FORCES? 1	YES 2		13.	If yes, s	pecklyCub	n, Mexica	n, Puarto Ri	can, atc.)	Or NO-	Blec	k, White, atc.
-	3 X Widowed 4 Dive		IF YES, GIVE Y	MAR OR OATES			1 [] YES	s 2 1 NO	Specif	y:			Spec	ffy:
	277 monate 4 - pine	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,												White
	15. DEC	EDENT'S EDUC	CATION COMPRISING	16a. S	Give kind of	USUAL O	CCUPATI	ION		16b. i	KIND OF BUS	INESS/IND	DUSTRY	
u l	Elementary/Secondary (College (1-4 or 5	- 1	fe. Do NOT u	se retired.)	during m	IUSE OF WORK	ng					2.0
7	8	,-,2,	Conage (1-4 of 5	ν,	C	stodi					5	duca	+:	
3					Cus	51001	all	_					11101	
COMPLEIED	17. FATHER'S NAME (First, M							18, MOT	HER'S NA	ME (First, Mi	ddle, Maiden	Sumame)		
10	Boyd Lu	ther	Waters						Ess	ie		Gay	1	
	19a. INFORMANT'S NAME (9b. MAILING	ADDRES	S (Street	and Numbe			r, City or Town			
2	M-m. A	Variate *												21740
	Mary Anne							-	יויוע		gersto			21740
	20a METHOD OF DISPOSIT	ION	oval from State		E AND DATE			lame of		DATE	20c. LOC	CATION —	City or To	own, Stata
	4 Donation 5 Other			Mt.	View	Ceme	eter	·V		1-7-98	8 Sha	rosb	ura.	Maryland
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENJE //	//						a l Hor				
	.//.	- 11	////											
	1/11/4	0//	-1840		_	42	25 S	. Co	noco	cheag	ue St.	Wil	lian	nsport, MD
	23. PART 1. Enter the	iséases, or c	complications the	at caused the	leath Do	not enter	the m	ode of du	ing euc	h as cardi	ac or respli	reton, en	rest	Approximate
	shock, or h	eart failure.	List Dniy one car	use on each iid	ne.			000 01 03		ni us cuita	ac or respir	otory or	e at,	interval Between
	IMMEDIATE CAUSE (Fin	nai												Onset and Death
	diseese or condition	-	Acute	Bronch	onnei	moni	а							5 days
	resulting in death)	1		(OR AS A CONS										Juays
			01-bo	imana D	10000									Manu una
5 1	Sequentisity list condit	ipns,		imers D										Many yrs.
	if sny, leeding to imme	diete	DUE 10	(UH AS A CUNS	EUUENCE U	r):								
HILICALION	cause. Enter UNDERLY CAUSE (Disesse or inju		с											
	that initieted events	"	DUE TO	(OR AS A CONS	EOUENCE O	i OF):								
-	resulting in deeth) LAS	T	4											
3			0.											
	PART ii. Other significa	ant condition	s contributing to	deeth but not	resulting	in the u	ndariylr	ng csuse	given in	Pert I.	24a. WAS AN		248	. WERE AUTOPSY FINDINGS
DICAL											PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
5											1 YES 2	NO NO		DF DEATH?
Z S														1 _ YES 2 _ NO
	DID TOBACCO L	ISE CONTI	RIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆	NO [□ UN	CERTAI	NX				
SICIAIN	25. WAS CASE REFERRED T				ACE OF DEA									
2	EXAMINER?		HOSPITAL:			QTHE		-						
2	t 🗆 YES 2 💢 NO		1 inputiant 2	ER/Outpetient	3 DOA	4XI Nu	raing Ho	me 5 🗆 R	aaldence	8 🗆 Other	(Specify)			
	27. MANNER OF DEATH		28a. DATE OF		28b. TIR	AE OF JURY	28c. IN	JURY AT		28d. DESC	CRIBE HOW IF	UNY OC	CURED	
-		Pending	(month, c	ouy, reary		M		YES 2	NO					
0	2 Accidant	Investigation	28a PLACE (OF INJURY A1	home ferm	strast for	tory offi	lea		201 1 004	TION (Stmot a	and Mumba	e or Primal	Pouts Number
3 Suicide 8 Could not be detarmined 28. PLACE OF INJURY — At home, farm, streat, fectory, office building, atc. (Specify) 28. PLACE OF INJURY — At home, farm, streat, fectory, office City or Town, State)										rioute rumoei,				
COMPLE	29a. CERTIFIER 1 CER	TIFYING PHYSI	CIAN: To the beat o	f my knowledge,	daath occur	red at the	time, dat	te end plac	a, and due	to the caus	e(a) and men	ner es sta	ted.	
Ē	onal city													a) and manner as stated.
3				and the second second	- mountgut	On, in my	opinion,	Gallin DCCC	neu at me	r time, uate a	and place, wir	u dua to t	ita Causa(a) and marmer as stated.
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										D (Month, Day, Year)				
	6	List	Buch	6)				17/	774	Fry			110	105
2	30. NAME AND ADDRESS O	E DEDOON HE.	O COMPI Prep o	ISE OF DEATH	EM ON CT	Orint'		100	10	//			6/9/	.10
							-		44-	ن الم				
	1190 Mt. A	etna.h			,		JI.	E. B	. MO	oay				
	31. DATE FILED (Month, Day,	1997	32. REGISTR	a Paydon	yn.									
	31. DATE FILED (Month, Day,	7 1998	Sich	a Navidson	w. Gand	all								
					•									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Ethel Irene Wolfinger 01 03 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Avalon Manor Nursing Home Hagerstown Washington Hours Min. F. C.D. 25, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Pennsylvania 1□ M 2\ F Months Deys 220-58-3002 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits Md. Washington Hagerstown 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20751 Millers Church Rd. 21742 U.S.A. 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specity: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 8 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Jacob Eberly Amanda Lesher 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell A. Wolfinger Jr. (Son) 20754 Millers Church Rd. Hagerstown, Md. 21742 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Remarkation State 1998 Hagerstown, Md. Jan. Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home ennis Smithsburg, Md. 21783 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Final Cardine arreit disease or condition resulting in deeth) Due to (or es e consequence of): COTOTALY artery Due to (or es a consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Cerebrovascular Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Non insulin dependent diubeter

Physician /Medical Examiner

the buriel-transit

and

signed by

certificate

After this

in by the

Medical

within 24 hours efter death To the Funeral Director: completely filled in by the

The law requires that the death certificete be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospital

the the

death.

Physician

/Medical

Examiner

10a Stete

Funeral Director

Completed by

Be

Funeral

Director

Item 27 is marked other than "netural", or Items 23s or 28s-4 show other traumatic event, the Macical Examinar must be notified at

Il Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event

Baltimore,

filed within 72 hours efter death with the Maryland

Examiner Physician/Medical ģ Completed Be P Certification:

Pert II. Other elgnificent conditione contributing to death but not resulting In the underlying cause given In Pert I. 25. Wes case referred to medical examiner? Other: 4 Nursing I 1 ☐ Yes 2 No

28e. Date of Injury (Month, Day Year)

32. Registre

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

140

Julia Davidson

28b. Time of

	24e. Was en eutopsy performed?	24b. Were eutopsy findings eveilebte prior to completion of cause of deeth?	
	1 □ Yes 2 No	1 ☐ Yes 2 No	
th (Check only one)		
ome	5 ☐ Residenca 6 ☐ Othe	or (Specify)	
28	d. Describe how injury occurre	bed	
28	1. Location (Street and Number City or Town, State)	er or Rural Route Number,	

29a. Certifier (Check only one)

27. Manner of Deeth

1 Naturel

2 Accident

3 Suicide

4 ☐ Homicide

31. Date filed (Month, Day, Year)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner stated.

29c. License number

28c. Injury et Work?

29b. Signature end title of certains

5 ☐ Pending investigation

6 Coutd not be determined

030584

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

Greenspoon, MO Laurence

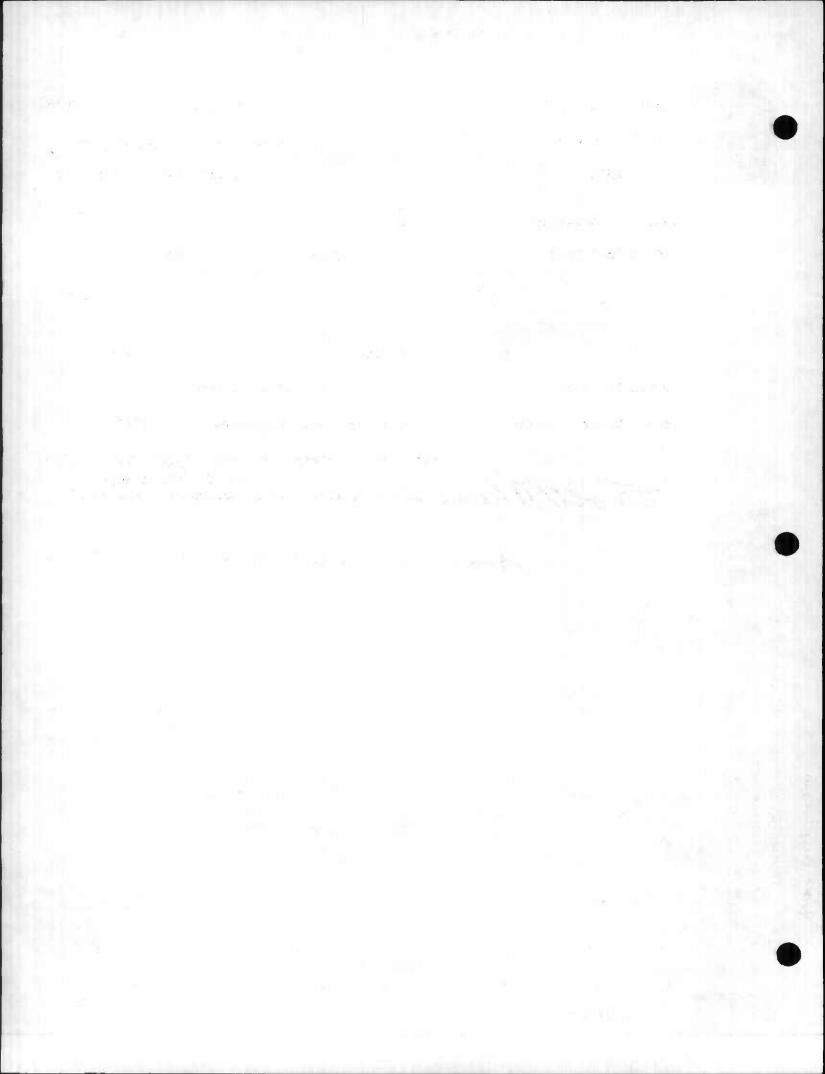
High St. / Spacock and. 21750

State Registrar

State of Maryland / Department of Health and Mental Hygiene 8 0 6 0 0

					Ce	ertifica	te of	Death		leg. No.		000	
Physician		1. Dacedent's Name (First, Middle, La							2. Dete of Dee Month	Dey	Yeer	3. Tima of Deeth	
/Medical	L	David Lynn YODE							Januar	1	-	1640	
Examiner	4	te. Fecility Name (If not institution, give						4b. City, Town, or	Location of Death	4c. County	of Deeth		
	4	Washington Coun	-			. 611.4	1 1		erstown		shingt		
Funeral Director			Sex 7. A	45	last birthday Yrs.	Months	er 1 Yeer Deys		8. Date of Birth (Month, Day Dec. 10,	? _{Yaar)} 1952	9. Birthple Country Mar	ce (State or Foreig y) y1and	
8 ■	-	10a. State 10b. County		10c. Cit	ly, Town or L	ocation					100	d. Inside City Limit:	
28a-f show colfrad at	,	W.Va. Berkel	ev		Ran	son			1⊠ Yes 2□				
7 28s		10e. Straat end Number					ip Code		10g. Citizen o			y?	
ms 23a or 28a-f show		104 Walnut Road					254	38		USA			
or its		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Wes Deceder Armed Forces 1 Yes 2 4 If Yes, Give Year or Dates	?] No	l,S. 13			Hispenic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - American ck, White, et y:		
"natural", edical Exe leted by		15. Decadant's E (Specify only highast gro	ducetion	etion 16e. Dacedent's			uei Occu	petion	rking	16b. Kind of B	usiness/Indu	istry	
ene. than "r na Med		Eiamantary/Secondary (0-12)		Coilage (1-4or 5+)			use retire	ed) ed)	rking				
gien t, me		12	0		t	raine	r			race h	orses		
d oth		17. Father's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middle,	Maiden Suman	ne)		
Mant arked		David Lee Yoder						Evel	yn School	ley			
and s m		19a. Informant's Name/Relationship (Type, Print)		19b. Mei	ling Addre	ss (Stree	at and Number or Ri	ural Route Numbe	r, City or Town	State, Zip C	Code)	
er tr		Evelyn Yoder - m	other					ve., Hage	erstown,	Md. 21	740		
Department of Heelth and Mantal Hygiena. Important: If Itam 27 is marked other than "n any injury or other traumetic event, the Med once. To Be Comple	2	20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □	Bomoval from Stat	20b. F	Place of Disp cematery, cr	position (Name and a local control of the local con	ame of other pla	ace)	Date	20c. Location	City or Tow	m, Stete	
int: H		4 Donetion 5 Other (Specify) Rest Haven Cemetery							1-10-98 Hagerstown, Marylan				
y Init		21. Signetura of Funeral Service Lice	nsee V		1	2. Name	end Addr	ess of Fecility	MINNICH	FUNERA	L HOME		
8 3 2 6		21. Signetura of Funeral Service Licenses 12 Name end Address of Fecility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740											
hysician /Medical xaminer	1	Immediate Ceuse (Finel disease or condition rasulting in death)	· Am	Due to to	rugh or as atons	equence of	Lax	eral Sc	lers.	6		Somet and Death	
ng physicten and s as the buriel-transit Medical Examiner		Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disaase or injury	b	Due to (c	or es e conse	equence of):				1		
nding physicien and use as the buriel-transit n/Medical Exami		resulting in death) Last	d	Due to (o	or es e conse	equence of):						
ed by the attendir detached for use Physician/N	-	Don't li Other electrice and an electric		h					001 0144				
y the	. '	Part II. Other significent conditions of	ontributing to death	but not res	ulting in the	undarlying	ceusa g	ivan in Pert I.				the cause of deat	
detache									1 U Y	es 2 No	3 Proba	ibly 4 🗆 Unkno	
ata hes been signed by paga 2 should be detr									24e. Wes e perfor		eveil	e eutopsy findings lable prior to pletion of ceuse seth?	
paga paga									1 □ Y	es 20 No	1 🗆	Yes 2□ No	
is cartificata director, pag fo Be Co		25. Was casa referred to madical examinar?						26. Plece of De	eth (Check only or	na)			
00		1 ☐ Yas 2 No	Hospital:	tient 2	ER/Outpetie	ent 3 [OA OI	ther: 4 Nursing I	Home 5 ☐ Resid	ence 6 □Ott	ner (Specify)		
e te e		27. Manner of Deeth 17 Natural 5 ☐ Panding 2 ☐ Accident invastigatio		jury lay Year)	28b. Time Injury	of M	28c. Inju	ory et ork?] Yes 2 □ No	28d. Describe h	ow Injury occur	rred		
rs after deeth. al Director: After t led in by the funera Certification:		3 ☐ Suicide 6 ☐ Could not be datarmined	286. Place of I	njury - At he	ome, ferm, s y)	treet, facto	ory, office		28f. Location (S City or Tow		ber or Rural i	Route Number,	
# # 50°		29a. Cartifiar (Check only one) LZ Certifying Pt	yelclan: To the bes niner: On the besis end mannar s	of examine	wiedge, dea tion end/or l	th occurre nvestigetion	d et the t	ime, deta end plece opinion, death occe	e, end due to tha c urred et the time, d	euse(s) and m date end place,	enner as ste end due to t	ted. he cause(s)	
Pletely Sletely		Orie)			2	9c. Licen	ise number		29d. Date signe	d (Month D	M 1		
within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7			29b. Signature end title of certifier								d (internet), Di	ay, Year)	
within 24 hours after deeth. To the Funeral Director: A completely filled in by the tr Medical Certificati		29b. Signature end title of certifier	3 () . m	4-			0	14800		1,0	3,9X	ay, Year)	
within 24 h To the Fun completely	1			death (Ita-	n 23a) /Tuna	Print\	0	14800 derich		1/9	7,98	ay, Year)	

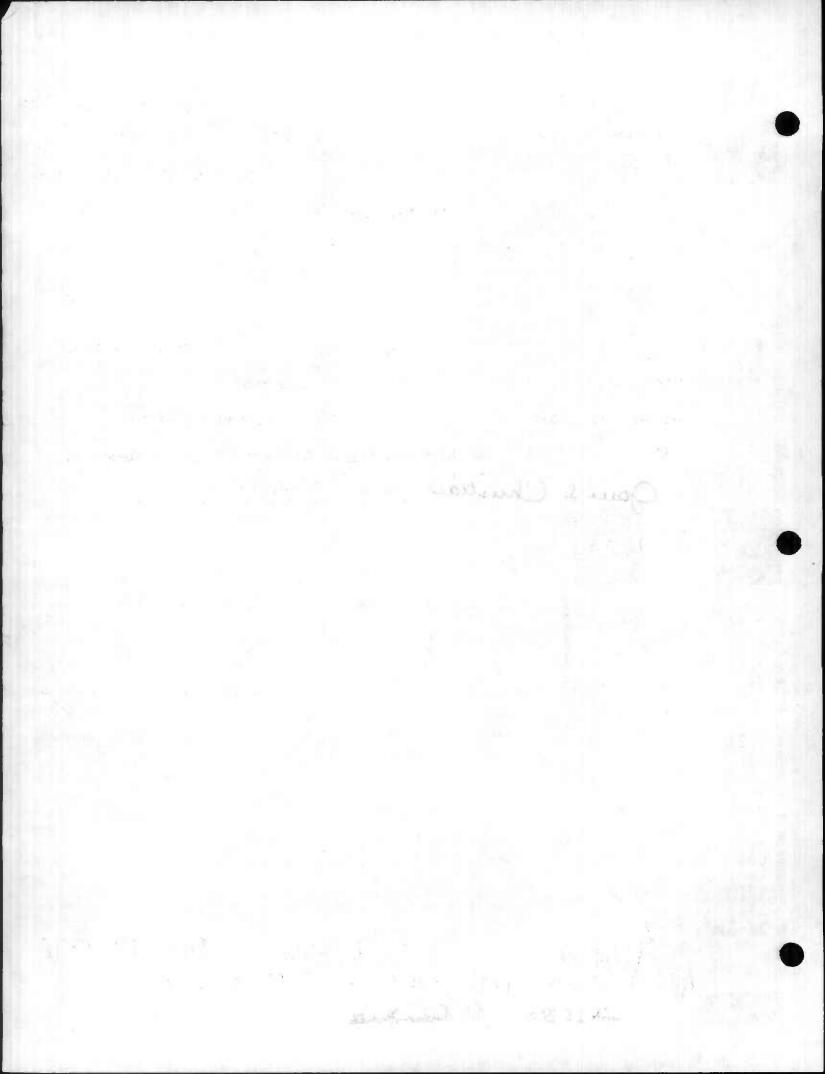
Yoder, David Lynn



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

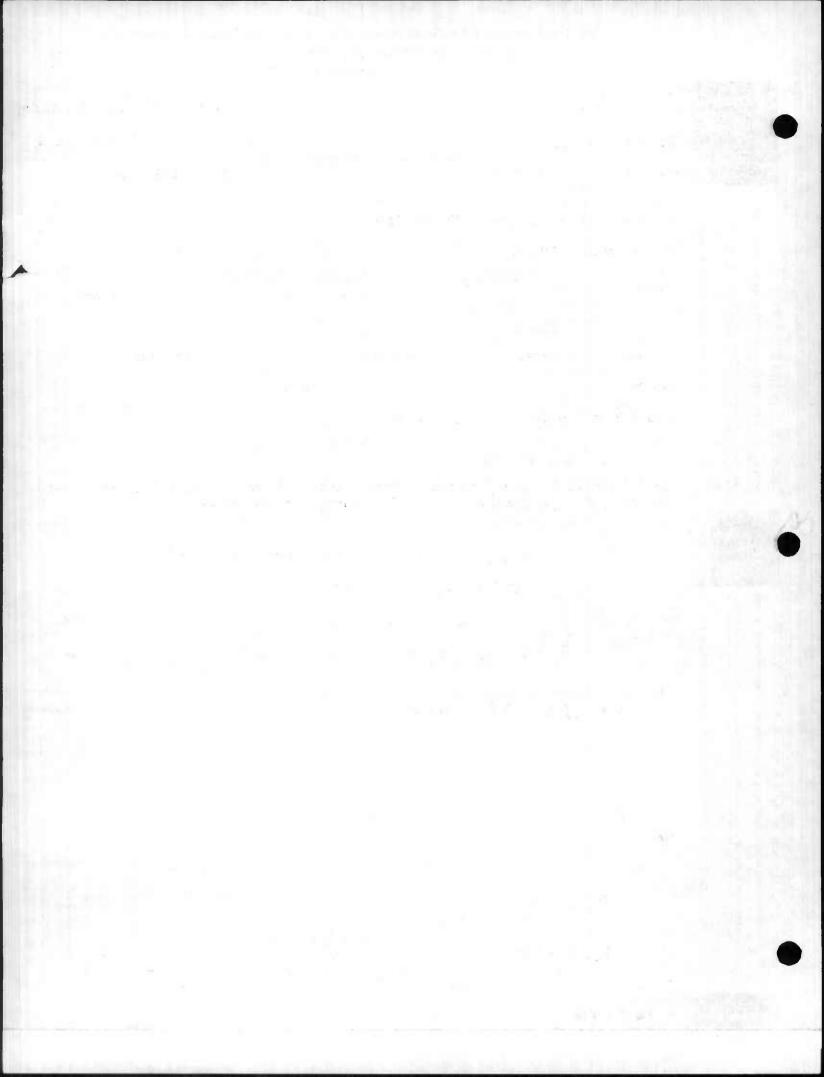
			AND THE RESERVE			Ce	rtificate	of Death		Reg. No.	0 10	UI	
ı	Physic	ian	1. Dacedant's Nama (First, Mide Effie B. Zei						2. Data of De Month	ath		ma of Daath	
	/Med Exam	ical	4a. Facility Nama (If not institution College View	on, giva straat and nu	mber)			4b. City, Towr	January n, or Location of Death	4c. Count	198 App by of Death lerick	. 1:30P	
-	_c Funera		5. Social Sacurity Number 236–22–5269	6. Sax 1 □ M 2 💢 F	7. Aga (In yr:	s. last birthday) 3 Yrs.		aar If Undar 24	Hrs. 8. Data of Bir Min. (Month, Da	th y, Year)	9. Birthplace (S Country)	tata or Foraign	
			Usual Residence of Dacedant 10a. Stata 10b. Count		10c. C	ity, Town or Lo	ocation		March O	8,1924	West Vi	rginia da City Limits	
	23e or 28a-f show	rector	WV Jeff	erson		Charles	Town	10		1 ☐ Y			
	eth with	ral Di	103 Fox Croft	Circle-Jef	ferson	Villag				what Country?			
020	72 hours efter deeth with the Maryland netural, or items 23e or 28e-f show sidel Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Nevar Marriad 2 □ Ma 3 ☑ Widowad 4 □ Divorce	rried 1 Yas	va		Was Decedant If Yas, specify (1 ☐ Yas 2 ☑		n? (Specify Yas or No Puarto Rican, atc.)	- 14. Ra Bia Specia	ce - Amarican India ack, Whita, atc. by: Whi		
21215-0020	in 72 hours n "netural", legical Eng	Completed	(Specify only high	nt's Education ast grada complated)		16a. Deced	dent's Usual Oc kind of work do	ccupation ona during most o	f working	16b. Kind of E	Businass/Industry		
	filed within Hygiene. rther than "	Comp	Elementery/Secondery (0-12) 12+	Collega (1-4or 5+)		ner's A	ide			tary Sch	ool	
rland	should be filed within and Mentel Hygiene. marked other then imatic event, the Mentel	To Be	17. Fathar's Nama (First, Middla Herbert Slushe:						Nama (First, Middle, Perks	Maidan Suma	ma)		
, Maryland	1 end 2 should Health end Men em 27 le marke other traumatic		19e. Informant's Name/Ralation Dale R. Zeigle						or Rural Routa Numb Hedgesvill				
Baltimore,	8 4 2 0		20a. Mathod of Disposition 1) Burial 2 Cramation 4 Donation 5 Other (5		Cinto	camatary, cran	osition (Nama on matory or other Masor	place)	Data Cery 1/13/		- City or Town, Sta dleway,		
Ball	permit. Page Department of Important: if eny Injury or otice.		21. Signatura of Funaral Sarvice	Licensae Chu	istia	UN	lelvin ⁻		er Co.,Inc		414		
ox 68760,		√Medical Examiner	23a. Part1. Enfer the disease, o shock, or heart fellura. Lis Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated avants resulting in death) Last	a. R b	Dua to (rocen	juance of):	Bleed				I Between and Deeth	
0	the deeth y the etter sched for u	Physician	Part II. Other significant condition	ona contributing to de	aath but not ras	sulting in tha ur	ndartying cause	givan in Part I.	23b. Did 1	obacco uae co	entribute to the car	usa of death?	
ls, P.0	es that gned b	by	approxim	- freun	ma				10	∕es 2□ No	3 ☐ Probably	4 Unknown	
of Vital Record	9w 2 S	Completed	U						24a. Was perio	an autopsy mad?	24b. Wara auto available p completion of death?	nor to	
la F	Pa age		25. Was casa referred to medica	1					101	-	1 🗆 Yas	2□ No	
>		ro Be	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	npatiant 2	ER/Outpatien	t 3 DOA	-	Death (Chack only only only only only only only only		nar (Specify)		
ono	After After fune	tion: T	27. Mannar of Deeth 1 Neturel 5 □ Pendir 2 □ Accident invasti	28e. Deta (Moni		28b. Tima of Injury	28c. I	njury et Nork?	28d. Describe h				
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accidant Invasti 3 Suicida 6 Could 4 Homicida datam	not ba	of Injury - At h	oma, farm, stra fy)	aat, factory, offi		28f. Location (S City or Ton		ber or Rural Routa	Numbar,	
	To the Hospital within 24 hours of To the Funerel Completely filled	edical	29a. Cartifiar Certifyir (Check only one)	Exeminar: On the be	bast of my kno asis of axamine har stated.	owiadga, daath etion and/or inv	occurred at the	a tima, data and p y opinion, daath o	lace, and dua to tha occurred et tha tima,	ausa(s) and ma lata and place,	annar as statad. and dua to tha cau	sa(s)	
i de	To the To the Comple		29b. Signat A and titla of certifia		iai sialau,		29c. Lic	ansa number	1	29d. Data signa	d (Month, Day, Yas	799	
			20. Named and address of person	who complated caus	a of deeth (Iter	n 23a) (Type, I	Print)	600	.	.(10,		10	
	Sta	te	31) Data filad (Month, Dey, Yaar)	32. A	egistrar Simi	INC /	NZ	FRE	C CM D	1702			
	Donietr	re.	IAM 1	6 1000 N	1.2. 1	500 9	0 000						



State of Maryland / Department of Health and Mental Hygiene 8

					Certificate	of Death		Reg. No.	010	200
hysician /Medical	1	1. Decedent's Neme (First, Middle, La Wilber		Allei	1		2. Date of De Janua	Dev	Yeer 1998	Time of Deeth
Examiner		be. Fecility Name (If not institution, give Laurel Region	1 1 1	spital		4b. City, Town, or Laur	Location of Deeth	4c. County		orge's
uneral rector		dikilowii		ige (In yrs. last bir	Yrs. If Under 1 Months	Year If Under 24 Hrs Deys Hours Min		th y, Year) ., 1937	9. Birthplece Country) Ohio	(Stete or Foreign
* 11	-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	n or Location				10d.	Inside City Limits
filed of	5	Maryland Prince	Georges	Hyatts	ville					1 ☐ Yes 2 ☒ No
at be notified		10e. Street end Number 2619 Nicholson S	treet		10f. Zip 0			U.S.A.		
Examiner must be notified at by Funeral Director	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes	nknown	13. Was Decede If Yes, specif	nt of Hispenic Origin? (§ y Cuben, Mexican, Puer No Specify:	Specify Yes or No rto Rican, etc.)	- 14. Rac Blac Specify	e - American I ck, White, etc.	
dical	7010	15. Decedent's Ed (Specify only highest gre	ducation de completed)	16a.	Decedent's Usuel (Give kind of work	Occupation done during most of wa	orkina	16b. Kind of Bu	usiness/Indust	ry
t, the Medical J	1	Elementery/Secondary (0-12)	College (1-4or			done during most of wa retired)				
		unknown u	nknown		unknown	18. Mother's Na	ame (First, Middle,	unknown		
To Be	5	unknown				unknow		17.0001 0 07.7011	,	
T		19a. Informent's Name/Reletionship (Ronald Potts/cou	Type, Print) Sin		Melling Address (Street end Number or R		er, City or Town,	Stete, Zip Co	de)
ury or othe		20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specification)) in stat	e cemeter	Disposition (Nemo		Dete	20c. Location -	City or Town,	Stete
any inj	1	21. Signature of Funeral Service Licer Ronald S 23a. Pert1. Enter the disease, or com- hock, or heer failure. List only	Meller		State A	Address of Fecility Anatomy Boar ore, Marylar	nd 21201		imore S	Street
ian cal ner		Immediate Cause (Final diseese or condition resulting in deeth)		Due to (or es e	Consequence of):	CHEARK THY	FAIC	756	On I	Yen
ounal-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	. +	Due to (or es e					2	yea
for use as the burial-transit	200	that initiated events resulting in deeth) Lest	ACO	Due to (or es e c		muno ?	Efic.	CIENCY YMPROPE		Year
etached for use Physician/		Pert II. Other algnificant conditions of	ontributing to death	but not resulting in	the underlying car					cause of death?
be detached by Physic		RENAG	- FP.	16086			1 🗆	Yes 2 No	3 Probabl	y Asanknown
2 should								en eutopsy med?	aveilet	eutopsy findings ble prior to etion of cause th?
Com							101	res 2 Ao	1 □ Ye	es 2 No
o 0		25. Wes case referred to medical examiner?	11 % 1				eth (Check only o	ne)		
		1 Yes 250No	Hospitel: 1 ☐ Inpat				Home 5 ☐ Resid			
completely filled in by the funeral d		27. Menner of Deeth Paturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ey Year) 28b. T	ime of 28 njury M	c. Injury et Work? 1 Yes 2 No	28d. Describe I	now Injury occur	red	
lled in by		4 ☐ Homicide determined	building, e	tc. (Specify)	m, street, fectory,		City or Tov			
pletely fill edical		29a. Certifier (Check only one) Check only 2 ☐ Madical Exam	ysician: To the besi niner: On the besis end menner s	of examinetion end	deeth occurred et Vor Investigetion, i	the time, date end plece n my opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) end me dete end place,	enner es stete end due to the	d. cause(s)
Comp		29b. Signeture and title of certifier			29c.	License number		29d. Date signe	d (Month, Day	, Year)
		Unote	to)	19971		1/16	158	
	3	10. Name and address of person who was the KA	completed cause of	76(a C	Type, Print) ARROL	AYE +	234, 17	md 2	= far	٤
State	:	31. Date filed (Month, Day, Year)	32. Regis	trar's Signeture						

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Leroy W. Applegate January 18, 1998 9:35 PM 4a. Facility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death 4301 East Joppa Road Baltimore Baltimore If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Dey, Year)
April 24, 1923 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number If Under 1 Yeer 9. Birthplace (Stete or Foreign Country)
New Jersey 7. Age (In yrs. lest birthdey) Months 215-12-5455 Yrs. 74 Usuel Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 East Joppa Road 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12th grade Salesman 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Rou K. Applegate Helen Jouce 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Geraldine Applegate (wife) 4301 E. Joppa Rd., Baltimore, MD 21236 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem'l Gard. 1/21/98 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Homes, Inc. Tobus 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . Renal Cell Carcinoma, metastatic tolung 10mo Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure, Diabetes mellitus, 24b. Were autopsy findings available prior to completion of ceuse of deeth? Hyperkusion, Amal fibrillation 24a. Was an autopsy performed? Deriphira / Vascular disease

25. Was cese referred to medical exemine? 1 ☐ Yes 2 Ho 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23e or 28a-f show treumatic event, the Medical Evantiner must be notified at

the Maryland

death v

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "rany Injury or other treumstit."

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital Attending Physician:

Examiner P

Completed by Physician/Medical Be

physician and the burial-transi esn Medical Certification: 24 boors after death.
Funding Director: After etch by the After

State Registrar

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Matural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Sertifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

D42979

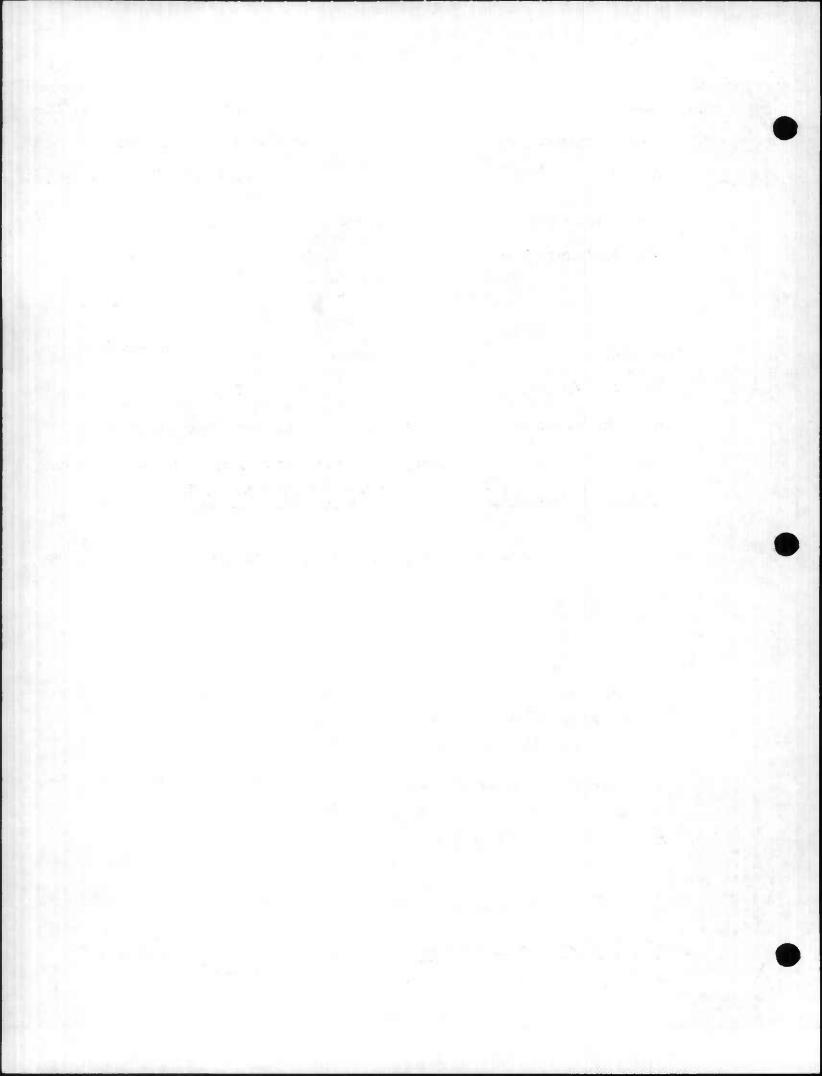
29d. Date signed (Month, Dey, Year)

29c. License number

30. Name end eddress of person who completed cause of death (Hem 23a) (Type, Print) Dr. Michael Carducci Balhmore MI) Wolfe

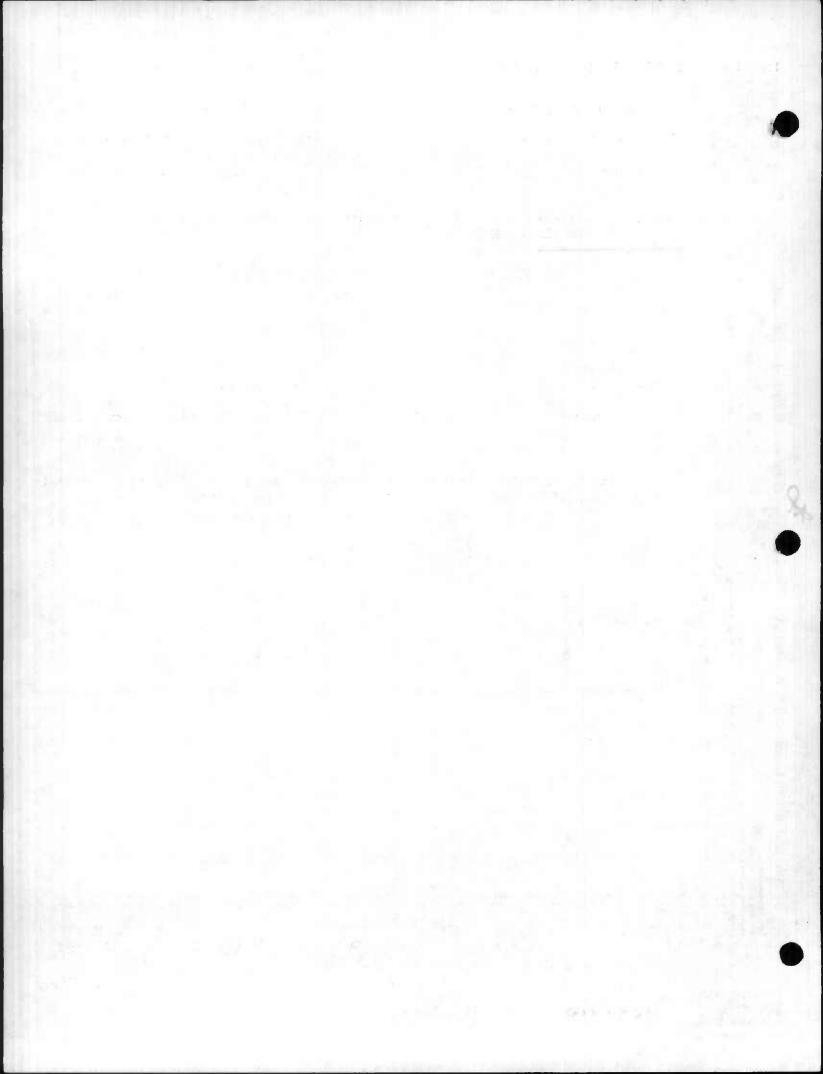
29b. Signature and title of pertifici

within 2 To the complet



It	tem: 10e H	Per	MEO Film G-755 1-26-98F		/larylan				Health and M Death		giene Reg. No. 9 8	01	604
1			1. Decedent's Name (First, Middle, Last)						2. Dete of Dee	oth		3. Time of Death
	Physic /Medi		Esther Young	Blake						January	Day 20	Yeer 1998	10:12 am
	Exami		4e. Fecility Neme (If not institution, give		r)				4b. City, Town, or L		4c. County	of Death	
			Union Memorial H	ospital	17.55				Baltimor	е	Balt	imore (City
	Funeral Director		5. Social Security Number 6. Se 216-20-3069	7. A	Age (in yrs. 82	lest birthday) Yrs.	If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) Sept.	7, Yeer) 21, 191	9. Birthplec Country, 5 Mary	e (Stete or Foreign 1 1and
	land w		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d.	Inside City Limits
	r 28a-f show	to	Maryland Baltimo	re	Ba1	timore	Coun	ty					1 ☐ Yes 2 ☒ No
	filed within 72 hours efter death with the Maryland Hygiene Hydiene Trans 23a or 28a-f show Int, tra Medical Evanting must be notified a	by Funeral Director	10e. Street end Number 6000 BEL 6000 Belona Avenu		AVENUE 10f. Zip Code 21212						U.S.A		?
	urs efter dea al', or items	Funer	11. Marital Status 1 Never Married 2 Married	12. Was Deceden Armed Forces 1 \(\text{Yes} \) 2 \(\text{L}	?	S. 13. V	Vas Decede Yes, speci	ent of H	dispenic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Red Ble	ce - American ck, White, etc.	
21215-0020	hours effure!, or	d by	3 √Widowed 4 □ Divorcad	If Yes, Give Yeer or Dates	7		☐ Yes 2				Specify		
215-	in 72 n "nat	Be Completed	15. Decedent's Edu (Specify only highest grede	completed)	- \	16e. Deced (Give i life. D	ent's Usuel kind of work OO NOT use	Occup done retired	petion during most of work d)	ring	16b. Kind of B	usiness/Indus	try
	d with giene.	EOC	Elementary/Secondery (0-12) 12	College (1-4o	r 5+)		tor C				Federa	1 Gove	rnment
Maryland	S a b ≥	To Be	17. Fether's Name (First, Middle, Last) Samuel Murice You	ıng					18. Mother's Nam		Maiden Sumen	10)	
			19a. Informent's Name/Relationship (Ty. Donald Young/broth						end Number or Rui eld Avent				
Saltimore,	Pages 1 and the total of Head int: If Item		20e. Method of Disposition 1 Buriel 2 Cremetion 3 R 4 Donation 5 Other (Specify)	emovel from State	- 04	lace of Disposemetery, crem	sition (Nem	e of her pied	ce)	Date	20c. Location -	City or Town,	Stete
Balt	permit. Pages Department of Important: If I any Injury or once.		21. Signeture of Funeral Service Licenses Ronald S	Wade, D	irect				ssof Fecility Boa			timore	Street
de la	Dhyololon		23e. Part1. Enter the disease, or complishock, or heert failure. List only or	cations that cause e ceuse on eech	ed the death line.							Ap Int Or	oproximate tervel Between nset end Deeth
9	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	mul	tisy:	stem	orgo	an-	failure			10	veeks
	D #	her		3200	Due to (or	r es e consequ	uenca òf):					2	weeks
	te be executed ysiclan end te buriel-transi	Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury	0		es e consequ	ence of):						
3760,		calE	thet initieted events	Perit	On) Due to (or	es e consequ	ence of):	_				1	weeks
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, G.	death	sicle	Pert II. Other eignificant conditions con	tributing to death	but not resu	Iting in the un	derlying cau	use giv	en in Pert I.	23b. Did to	bacco uee co	ntribute to the	e cause of death?
S, P.C	requires thet the death certifica been signed by the attending ph should be detached for use es th	by Phy	Ne phro lithia							1 🗆 Y			ly 4□ Unknown
Bla	9 90	Completed								24e. Wes e perfor	n eutopsy ned?	evallet	eutopsy findings ble prior to etion of cause th?
H		Con								1 🗆 Y	s 2.ZNo	1 □ Ye	es 2MNo
- ; ts	Physician: The levels this certificate has ral director, pege 2	Be	25. Was case referred to medical examiner?	nanitat :					28. Place of Deat	h (Check only or	e)		
of	2 00	5	10 165 2E(110	ospital: 1 Inpat		ER/Outpatient			4 I Nursing Ho	me 5 Reside			
	Attending Ph r death. ector: After th by the funeral	tlon	27. Manner of Deeth 1. Naturel 5 □ Pending 2 □ Accident Investigation	28a. Dete of Inj (Month, De	ey Yeer)	28b. Time of Injury	M 286	c. Injun Worl	y et k? Yes 2 □ No	28d. Describe h	ow injury occur	red	
ther		Certification:	3 Suicide 6 Could not be determined	28e. Plece of In building, e	jury - At hor tc. (Specify)	me, farm, stre	et, factory,			28f. Location (Si City or Town	reet and Numb n, State)	er or Rural Ro	oute Number,
11	the Hospital or nin 24 hours effe the Funeral Dir npletely filled in	edical	29e. Certifier (Check only one) 1 Certifying Physical Examin	clan: To the best er: On the basis of end manner si	of exeminati	viedge, deeth on end/or inve	occurred et estigation, in	the tim	ne, dete end pleca, plnion, deeth occurr	end due to the c ed et the time, d	euse(s) end me ate end place, o	nner es stete end due to the	d. cause(s)
41	To the To the Comp	Z	29b. Signeture endititle of certifier	11			29c. l	License	e number	2	9d. Date signed	d (Month, Dey	, Year)
•	17.74		4 adiene	Hay	Mes	MD	A	T	24389	146 7	anvary	, 20	1998
			30. Name and address of person, who cor	es mi	2	01 0	nint)	sity	Parkwy	Balt	more 1	Panylan	121218
	Star Registra	16	31. Dete filed (Month, Day, Year) JAN 2 6 1998	32. Regist	rer's Signat	Pandell							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth

				State of Marylar	nd / Departme <i>Certifica</i>				leg. No.	01605	
	Physicia /Medic		Decedent's Neme (First, Middle, Last) ROBERT		BRO			2. Dete of Dee Month	Day 24, 1	Yeer 998 1:45	
	Examin	er	4a Facility Neme (If not institution, give			4b.		ocation of Deeth	4c. County		
			Saint Joseph M 5. Sociel Security Number 6. Securi		1 68.63	der 1 Year	TOWS C	8. Date of Birth		altimore (State or	Foreign
L	Funeral Director			(M 2□ F	Yrs. Month		Hours Min.	(Month, De)	2,1931	9. Birthplace (State or Country)	
	1215-0020 within 72 hours effer death with the Maryland ana. than "natural", or items 23a or 28a-1 show the Medical Examiner must be modified at		10a. Stete 10b. County 10a. Street end Number 3404 Ludge 11. Marital Status	ate Roc 12. Wes Decedent Ever in U	d	ODCE Zip Code	215	pecify Yes or No-	log. Citizen of V	10d. Inside City 1 Yes Whet Country?	•
020	urs efter d al', or iten	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No IYes, Give 3	If Yes, s	pecify Cuban,	, Mexicen, Puerto Specify:	Rican, etc.)		k, White, etc.	
121215-0020	filed within 72 ho Hygiana. rther than "neturi ent, ne Wedeal	To Be Completed	15. Decedent's Edur (Specify only highest grede Elementary/Secondary (0-12)		life. DO NOT	work done du use retired)	ring most of wor		Bethle	ehem St	ee
Maryland	should be find Mental Finanked ot	To Be	17. Father's Neme (First, Middle, Last) William Bi	rown	40h Maille Adda		Mini	ne (First, Middle,	Pierc	e	
Baltimore, Ma	permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Exercises caust be notified at once.		19a. Informent's Name/Relationship (Type) 20a. Method of Disposition 1 Burial 2 Cremation 3 S 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Brown 20b. Lemoval from State	Place of Disposition (forcemetery, crematory of	data Verne di or other piece) orest (e Rd., emeter, of Fecility prown J	Battim Dete 1-29-98	Done M 20c. Location - Doing	oryland 21 City of Town, Stete SMills, M	1218 Leyl
	Physician /Medical Examiner	ner	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in deeth)	SMALL CEL	th. Co not enter the m	OMA OF	such as cardiac	or espiratory ar	rest,	Approximate Interval Betwood Onset end D	reen
Box 68760,	requiras that the death certificate be executed seen signed by the attending physicism and should be detached for use es the burn transitional death of the seen the seen the seen that the seen the seen the seen that the seen t	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to (or es e consequence o						
	death e atte ed for	sicia	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	a ceuse aiven	n in Pert I.	23b. Did t	obacco use co	ntribute to the cause of	f death?
s, P.0	as that the death certifi igned by the attending i be detached for use es	by Physician/Me	DIABETES MELL					101	\/	3 Probably 4 L	
Record	has t	Completed	HYPERTENSION			+		24e. Was a perfor	med?	24b. Were autopsy fir eveilable prior to completion of ce of deeth?	ouse
of Vital	ysician: The s certificeta director, pag	Be	25. Was case referred to medicel examiner?				26. Plece of Dee	th (Check only o	ne)		
7	5 00	2	1 ☐ Yes 2 No		ER/Outpatient 3	DOA Other	4 LI Nursing H	ome 5 Resid	ence 6 DOth	er (Specify)	
Division	or Attending Pefar death. Director: After the by the funeral	Certification:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury e Work? 1 ☐ Ye	et es 2 No	28d. Describe h			
DIVI	To the Hospital or Attending Phymin 24 hours eftar death. To the Funeral Director: After this completaly filled in by the funeral		4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)		data as delle	City or Tow	n, State)	er or Rural Route Numb	oer,
	Hospital 24 hours Funeral letaly filled	edicai	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	licien: To the best of my known or: On the besis of examinating and manner stated.	ation and/or investigati	on, in my opir	nion, death occu	red at the time,	ause(s) end ma date end plece,	inner as steted. and due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature end title of certifier	Pae no Ro	elfolgisv"	29c. License i			29d. Date signe	d (Month, Day, Year)	
	(V/	-	00.11							. , ,	

30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrer's Signature

33. Registrer's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kobert 11:58An January 17 1998 action of Death 4c. County of Deeth Franklin 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days -36-8913 Months Hours 1 M 2 F 56 220 Yrs. MAR 9, MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTO Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 N. CASTLE ST 21205 U.S.A. 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Yes 21 tho Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) CONSTRUCTION WORKER 12th CONSTRUCTION CO 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT BAGLEY SR GRACIE STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA BAGLEY 2531 E. OLIVER ST BALTO, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State JAN 22 1√2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1998 BALTO, MD MT. ZION CEM 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Candida albicans fungemia week Pneumocystis Carinii pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last cytomegalovirus Due to (or as a consequence of) Immunodoficiency Syndrome 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatlent 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

rai', or items 23a or 28a-f show

"natural", or

traumatic event, the Medical

nd Mental Hygiene. merked other than

Pages 1 and 2 should be finent of Health and Mental I int: if item 27 is marked of

nt of Health a if item 27 is or other tra

Depertment of Important: If any injury or

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

To the Hospital or Attending Physician: The law requires that the death certificate leading within 24 hours elect death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the innertal director, page 2 should be deteched for use as the burier-laristic completely filled in by the innertal director, page 2 should be deteched for use as the burier-laristic.

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be Certification: To

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Medicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the ceuse(s) and manner as steted.

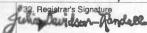
2 Madical Exeminar: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

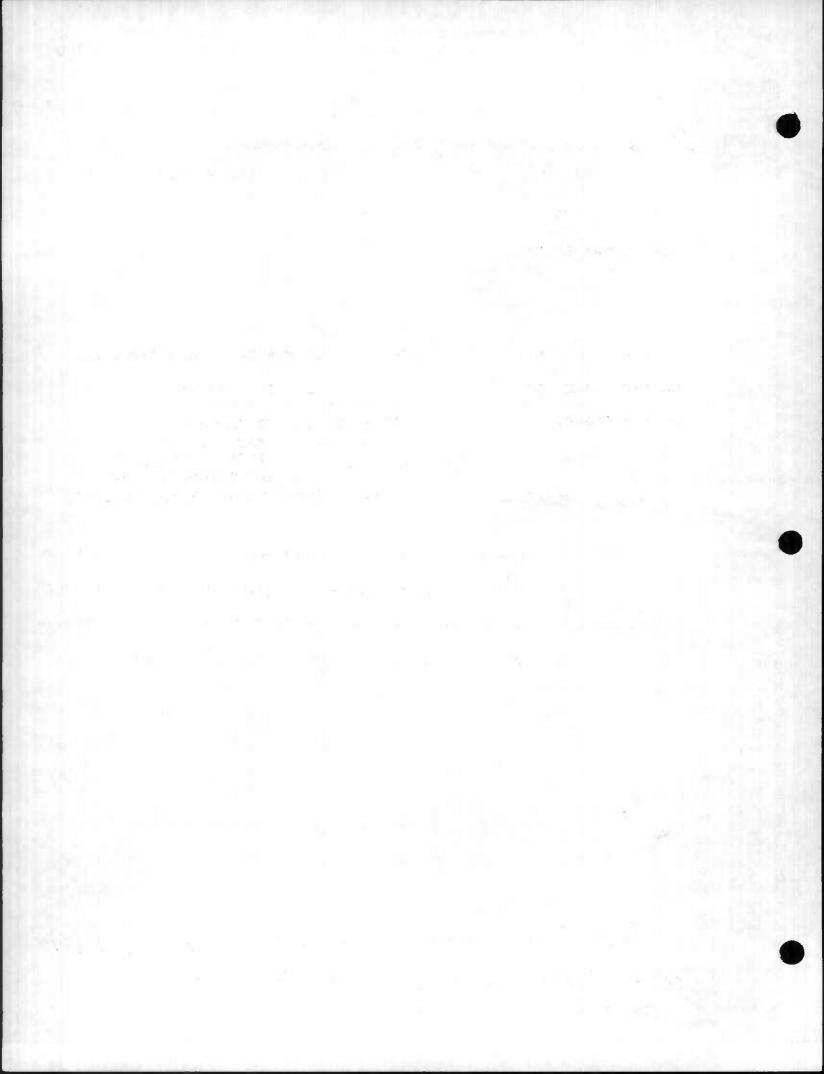
29b. Signature and title of certification thang mo 29c, License number 29d. Date signed (Month, Day, Year) RES 000 January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huspital Buttmore MD

State Registrar

31. Date filed (Month, Day, Year)



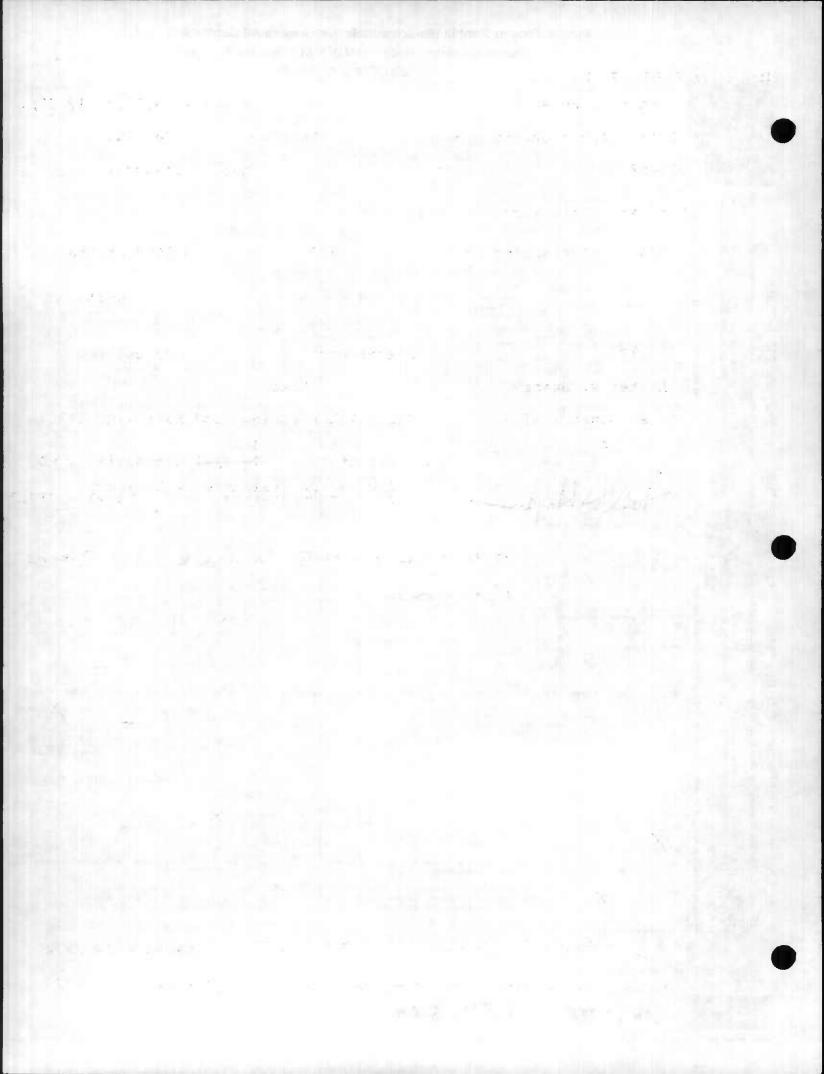


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene R Certificate of Death Item: 20b PenoFH Film G-755 1-26-98RC 2. Data of Daath 1. Dacedant's Nama (First, Middla, Last) 3. Time of Death January 24, 1998 **Physician** James E. Bussey 12:35pm /Medical 4a Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner 2013 Sulphur Spring Road Baltimore Baltimore | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplaca (Stata or Foraign (Month), Day, Year) | Quantity | 4 Ug • 22,1940 | West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 20 F 232-58-8870 57 Director Usual Rasidance of Decedent the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d Inside City Limits a or 28a-f show Baltimore Maryland Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zin Coda 10g. Citizan of What Country? 72 hours after death with 2013 Sulphur Spring Road 21227 United States res 23a Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? H∑Yas 2 □ No If Yas, Giva Yaar or Datas: "natural", or items Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify: White by 3 ☐ Widowad 4 ☐ Divorced r than "nature Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) filed within Elementery/Secondary (0-12) Collaga (1-4or 5+) Hygiene. Dispatcher Medical Lab 7 is marked other traumatic event. 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Be Pages 1 and 2 should be faced of themselved of themselved of Lester G. Bussey Hazel 19b. Malling Address (Straat and Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Patsy Bussey, wife 2013 Sulphur Spring Road Balto., MD 21227 item 2 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20c. Location - City or Town, Stata 1/29798 Metro Crematory 1/29/97 Catonsville, MD 5 Othar (Specify) 4 Donation 22. Nama and Addrass of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road Maryla Maryland21227 DODA 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** /Medical Immadiata Causa (Final disaasa or condition resulting in daath) Pro state Cance Examiner Due to (or es a consequence of): Examiner 4 comon ja that the death certificate be executed physician and s the bunal-trans Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): ettending ph for use as t signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to Completed complation of cause of death? certificate hes t 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medical examiner? 26. Placa of Daath (Check only one) Be 1 Yes 2 No Hospital: 1 | Inpatiant | 2 | ER/Outpatiant | 3 | DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 2 27. Manner of Deeth 28d. Dascribe how injury occurred 28b. Time of Injury Certification: 28a. Date of Injury (Month, Day Yaar) 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 Tyes 2 No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es statad.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated. 29a. Certifian (Check only one) 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) JANUARY 26,1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 CATON Ave. BALTIMORE, MARYLAND 21229 0, S. GALAGER

State Registrar

MICHAEL 31. Data filad (Month, Day, Year)

JAN 26 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death Brumfield WiLLIAM ANUARY 20 4c. County of Deeth 4e. Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death ospital Takoma Park Mc 7. Age (In yrs. last birthday) Months Deys Hours Min. Nov. 28, 19: Washington Adventist Hospital Montgomery 5. Social Sacurity Number 6. Sex Birthplaca (Steta or Foraign Country) 1 X M 2 □ F Pennsylvania 175-22-1366 Usuai Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2□No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 952 Nichols Drive 20707 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, Whita, atc. 1 N Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Classified Dept. of Defense 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George E. Brumfield Elizabeth C. Flohr 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Caroline M. Fowler/Wife 952 Nichols Drive, Laurel, Maryland 20707 20b. Plece of Disposition (Nema of cemetery, crematory or other piece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Cremati Ivy Hill Cemetery 1/23/98 Laurel, Maryland 22. Nama and Address of Fecility Fleck Funeral Home, Inc. or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximate Approximete intervei Between Onsat end Death Immediate Ceus diseese or condition resulting in death) month es e consequence of): Sequantielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated avents resulting in daath) Last Due to (or es e consequance of): Dua to (or as a consequance of): 23b. Did tobecco use contribute to the cause of death? Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 PNo 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiana. Important: if Item 27 is merked other then "naturel", or i any injury or other traumatic event

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Division of Vital Records.

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Examiner Physician/Medicai Be

Completed

To the Hosp within 24 ho To the Fune completely f State

by P Certification: 29a. Certifier Medical

25. Wes case referred to medical axaminar? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

Hospital: 1 □ hpatient 2 □ ER/Outpatient 3 □ DOA 28e. Date of injury (Month, Dey Year)

28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work?

1 Yes 2 No

Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

29b. Signature and little of certifier

29c. License number

GROVE

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

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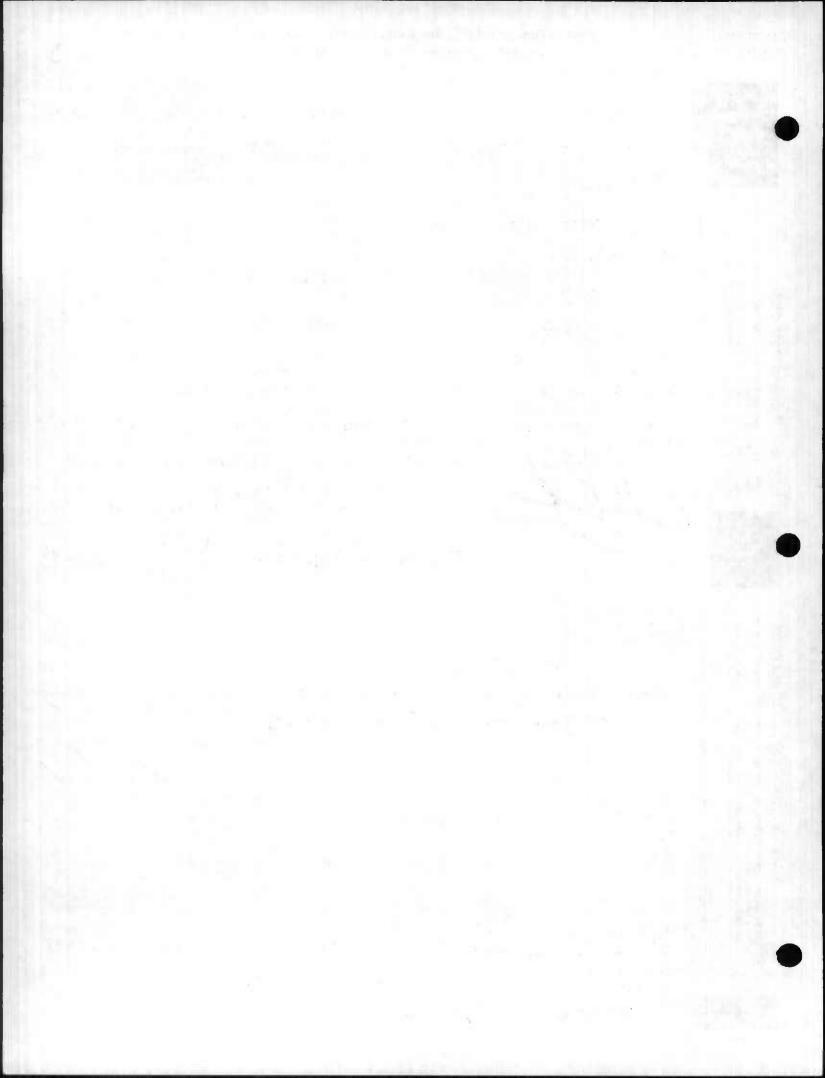
29d. Date signed (Month, Dev. Year)

s of person who completed cause of deeth (Item 23e) (Type, Print) SOTMOY 15225 MANOSINE

Day, Year)

32. Registrar's Signature Sha burg

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene WILLIAM BYRD Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** William Byrd JR. 18, JAN. 1517 PM 1998 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3715 GWYNN OAK AVENUE n/a BALTIMORE 8. Dete of Birth (Month, Dex. Yeer) NOV • 14,1942 If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 212-42-4535 7. Age (In yrs. last birthday). 55 Yrs. Birthplace (Steta or Foraign Country) **Funeral** Months Days Hours XXM 2□ F Yrs. Md. Director Usuel Residence of Decedent the Merylend 10c. City, Town or Location Baltimore 10e. Stete 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. n/a 1 XX Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21207 3715 Gwynn Oak Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours efter 1 ☐ Never Married ★ Married ty∑tyYes 2 No 1963 Maryland 21215-0020 1 ☐ Yes 3€No Specify: Specify: Black Ag 1966 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver National Freight traumatic event. 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health end Mentel Hant: If Itam 27 Ia marked oth Be Mary Fletcher Will Byrd 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3715 Gwynn Oak Ave. Baltimore, Md. 21207 Deborah Byrd other i 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Jan. 23 20c. Location - City or Town, Stete 1 □ Removel from State permit. Page Department of Important: If any Injury or once. č Owings Mills, Md. Garrison Forest Veterans 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funerel Service Licensee Herbert 2501 Gwynns Falls PKWY Baltimore, Md. nutter 21216 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician /Medical Immadiete Ceuse (Finel Arteriosclerotic Cardiovascular Disease diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner physician end the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): certificate be Physician/Medical Dua to (or as a consequence of): 80 use 0 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dld tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus A 24b. Were eutopsy findings aveilable prior to Completed 24a. Was an eutopsy peen completion of cause of deeth? INSPECTION hes 1 ☐ Yes XXNo 1 ☐ Yes 2 ☐ No

Box 68760 P.0. page 2 certificate of Vital director,

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Certification:

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Division

David Fowler, M.D. 31. Data filed (Month, Day, Year) JAN 26 1998 State Registrar

25. Wes case referred to medical

5 Pending

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6 Could not be determined

Yes 2□ No

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2 Accident

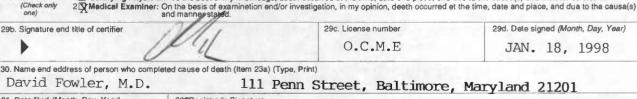
3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier



1 ☐ Yes 2 ☐ No

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted.

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home SAResidence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

320 Registrar's Signature a Davidson-Randell

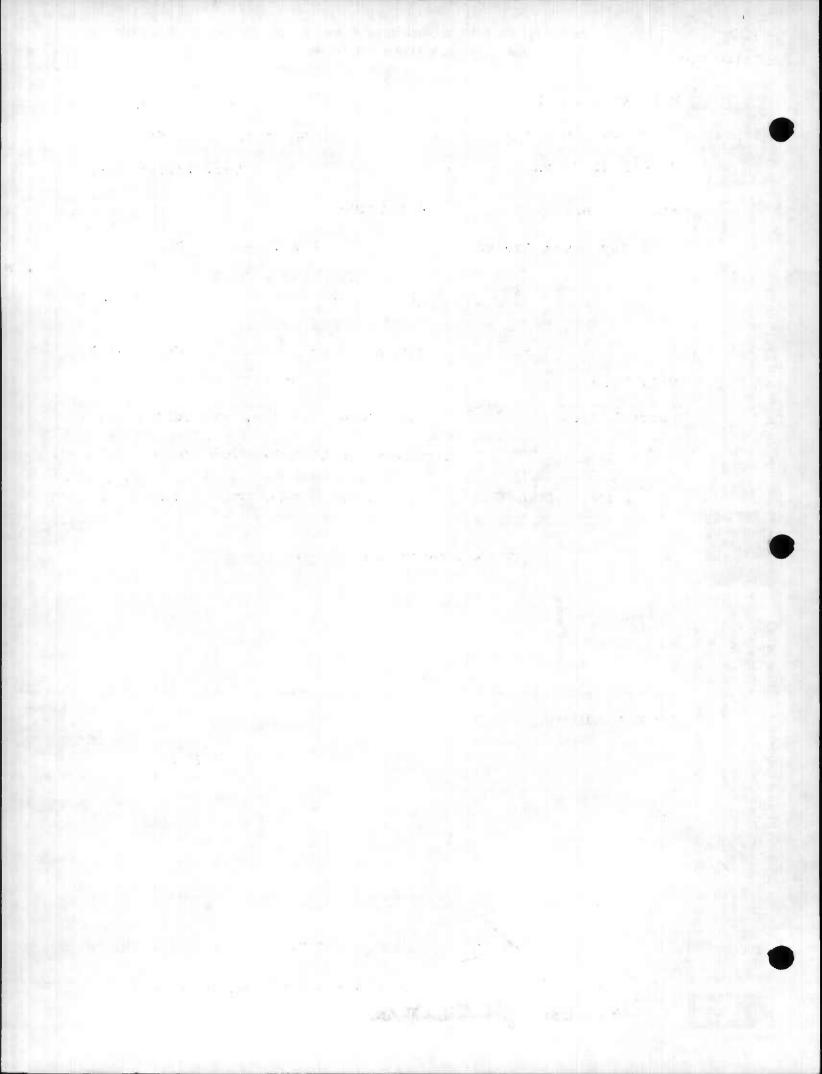
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month ARION BROWN 19, 17:05 P.M. JANUARY 1998 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL, 900 CATON AVENUE BALTIMORE n/a5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (Steta or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□ M 200 78 219-22-5687 March 15, 1919 Md. Usual Residenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Yes 2□ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Mt. Royal Avenue Apt. 1412 21217 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 □ Never Married 2 □ Married 1 ☐ Yes ★ No If Yes, Give Year or Datas: 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Beauty Salon Shampooer 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lessless Camper Mabel Cook 19e. Informant's Name/Relationship (Type, Print)daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Portia Brown White 4443 Pen Lucy Road Baltimore, Md. 21229 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or othar place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Jan, 24 Baltimore, MO. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses Herbert 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nutter 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Un Known disease or condition resulting in death) Myocardia Cardiovascular atherosclerotic UNKnown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) mellitus unknown diabetes Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 triknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yas 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer?

1 Yes 2 No 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manual of Deat 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner es tha burial-transit pue Division of Vital Records, P.O. Box 68760 physician

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Physician/Medical signed by the attending d be deteched for use es page 2 funerel director, 2 Certification:

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/Medical

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7 is marked other than "natural; or items 23s or 28s-f sho traumatic event, the Modical Examinar must be notified at

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filed within 72 hours aftar

Baltimore, Maryland 21215-0020

3 Suicide

29a. Certifiar

4 Homicide

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To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: Al completaly filled in by the fu

29b. Signature and title of certifiar

Jon takk MD. 31. Date filed (Month, Day, Year) JAN 26

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and mannar stated. 29c. Licensa number 29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

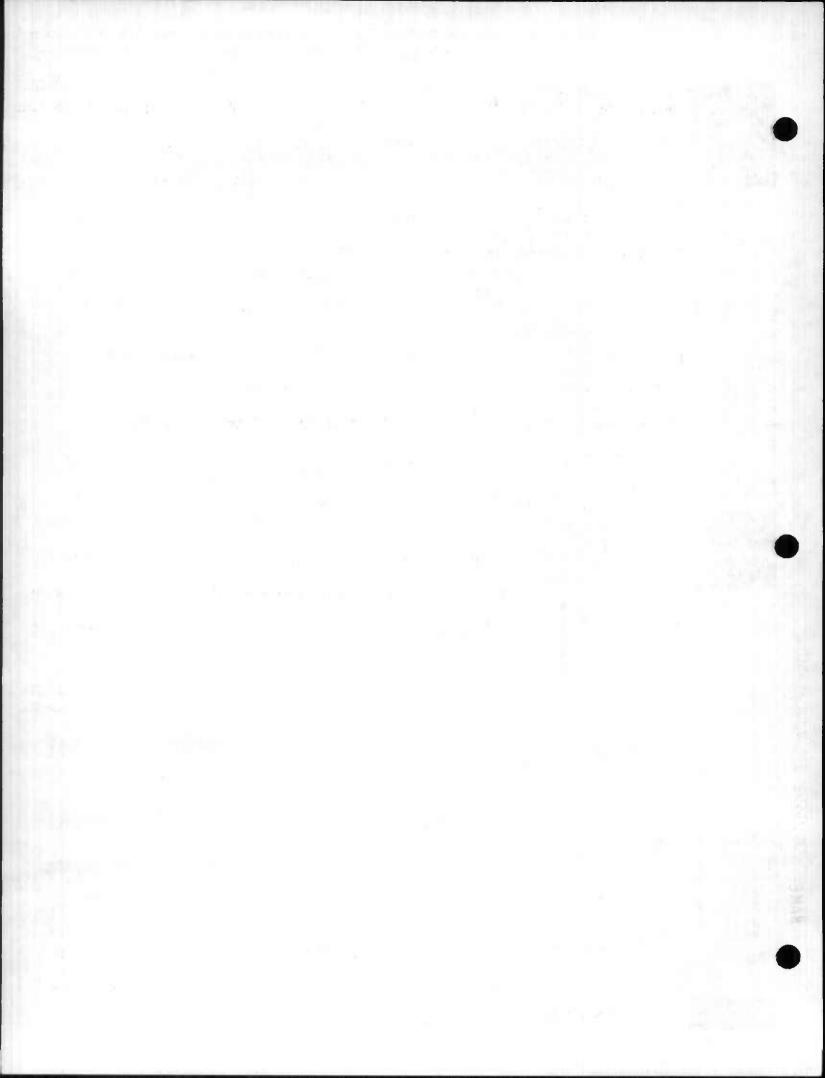
St. Agnes Hospital

32. Registrar's Signature

900 Caton Avenue Baltimore, Maryland 21229 who Davidson Randall

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Month **Physician** 6:35 pm William Thomas Cooney, Jr. Jan 98 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore Catons ville If Under 24 Hrs. 8. Dete of B Charlestown Care Center 8. Dete of Birth (Month, Dey, Yeer) Jan. 13, 1916 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 M 2□ F Months Deys Hours Min 214-03-2741 Yrs. Maryland Director Usuai Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2 ☑ No Director Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 711 Maiden Choice Lane 21228 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other that any injury or other traumatic event, the 2008. Supervisor Weather Instruments 12 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Neme (First, Middle, Last) Be William T. Cooney, Sr. Sarah Deborah Brandenburg 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21228 Carolyn E. Cooney/wife 713 Maiden Choice Lane, #1106, Catonsville, Maryland 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 ☐ Other (Specify) 21. Signeture Fundral Service Licensee Romald S. Wade, Director 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 maun 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Aspiration Pneumonia
Due to (or es e consequence of): Examiner Severe Orapharingen/ Dysphagin physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest P.O. Box 68760. Due to (or es a gonsequence Dementin Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributa to the causa of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown VarKinsons Disense Division of Vital Records. by 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 21 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: nin 24 hours after death. the Funaral Director: After this certifict nplately filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury accurred 28c. Injury et Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) To the within 2.
To the F

29c. License number

29d. Date signed (Month, Dey, Year)

Maiden Choice lane Catingville, MD, 21228

January 20 1998

State Registrar 29b. Signeture end title of certifier

Andres

31. Date filed (Month, Day, Year)

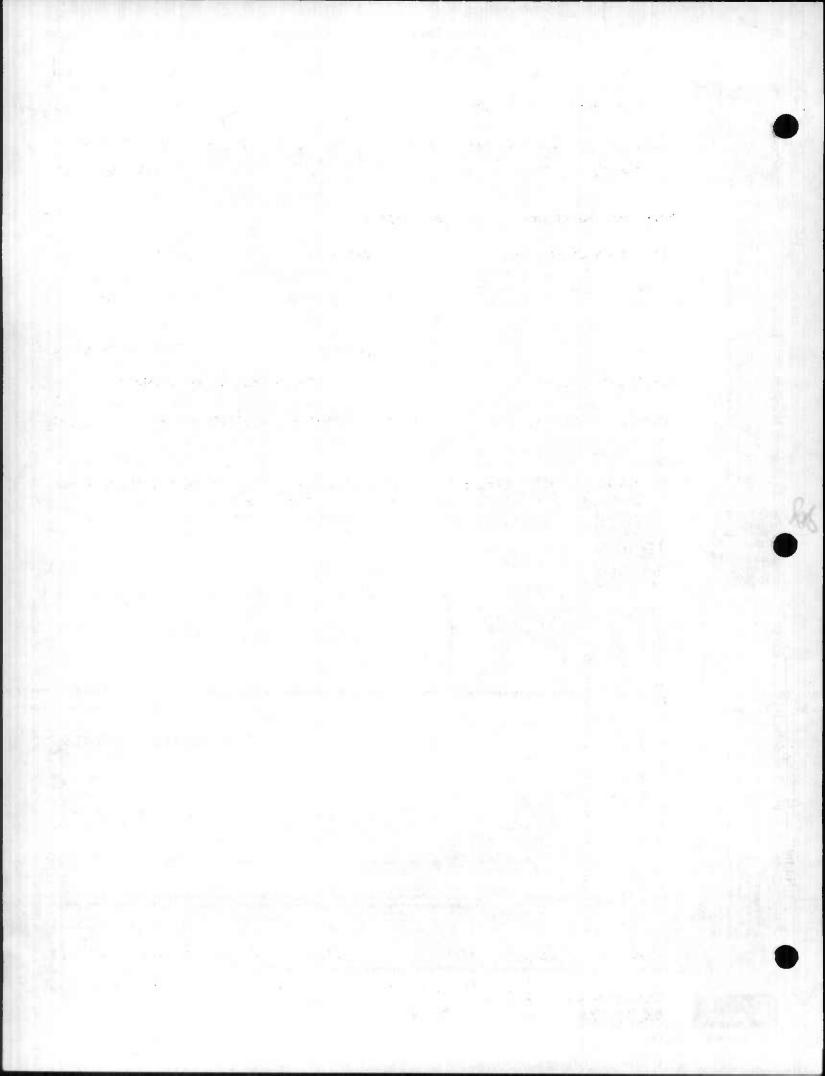
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when

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

192. Registrar's Signeture
War Durdon Arndelle

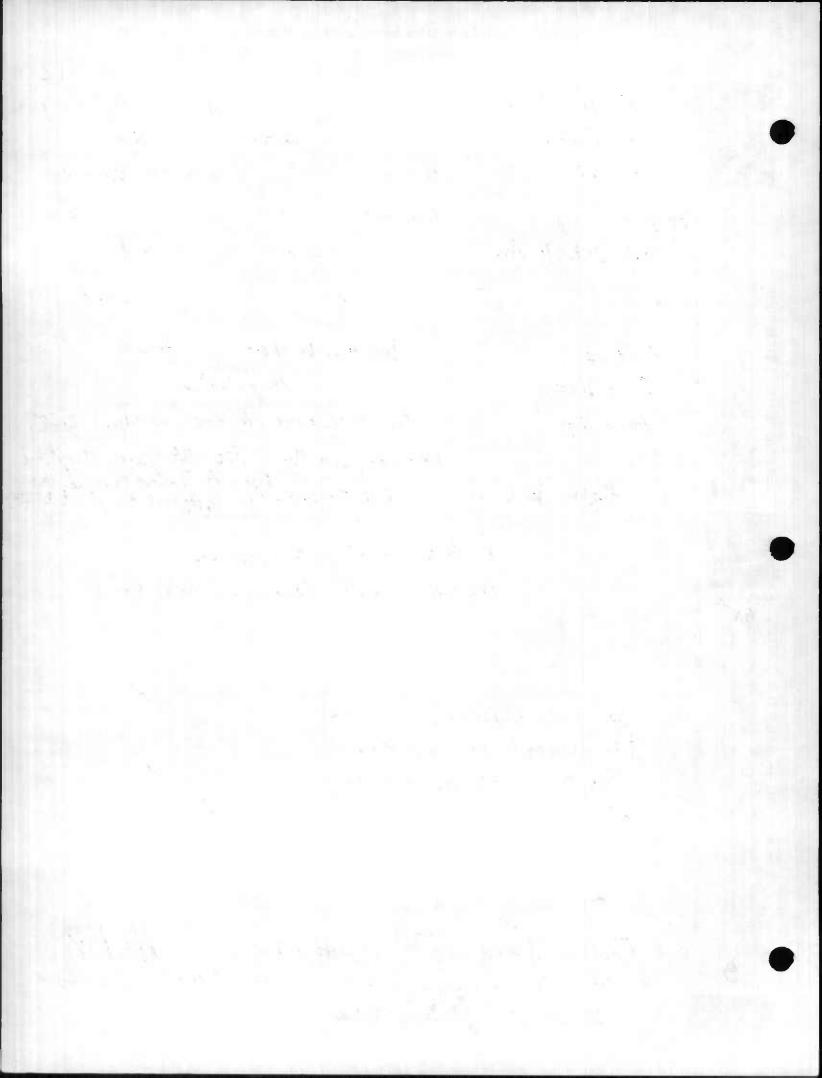
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Martha 01 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of De **Examiner** Orkhill Baltimere Hours Min. 8. Date of Birth Month, Dey, If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Deys 212-36-125 1□ M 2 F 93 Yrs. Director Usuel Residence of Decedent the Merylend 10e Stete 10b. Count 10c. City, Jown or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at Baltimore Yes 2□ No Director Maryand 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3013 21207 permit. Pages 1 and 2 should be filed within 72 hours after death very perment of Health and Mental Hygiens.

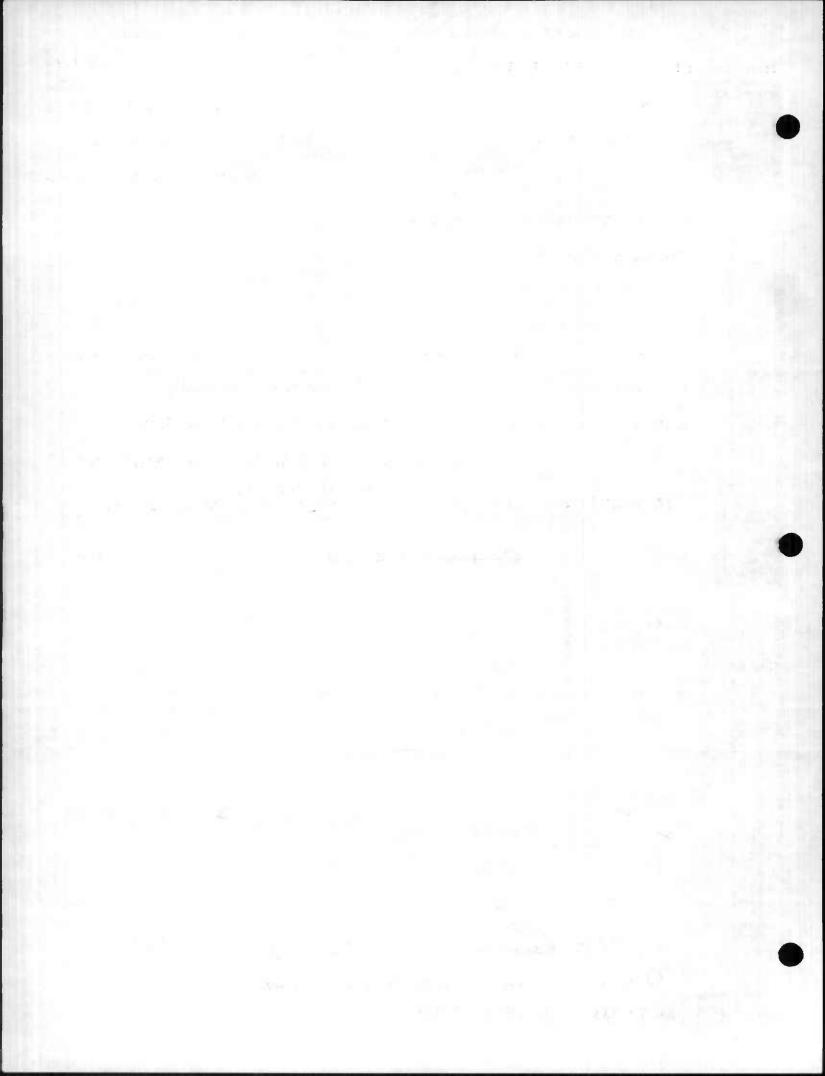
Important: If Itam 27 is marked other than "naturel", or Itams 28 and Injury or other traumatic event, the Medical Examination 2006. Funeral 12. Wes Decedent Ever in U,S. Armed Forceş?
1 ☐ Yes 22 No
If Yes, Give
Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0020 Specify: þ 3 Ø Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Private Domestic Worker ~ Grade 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Thomas Vanes 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Releţionship (Type, Print) Hayes Baltimore Mary 3013 Oakhill Maryland Ave. Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other page 200). 20a. Method of Disposition 20c. Location - City or Town, State 1 DrBurial 2 Cremetion 3 Removel from Stete Wood laws 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses flerin 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Cardioc arrhythme /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert tt. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. signed by t 2 No 3 Probably 4 Unknown tai by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 □ Yes 2 □ No 0 25. Wes cese referred to medical examiner?
1 ☐ Yes 2☑ No Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel or Attanding 5 Pending investigation 2 No To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Af 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Sulcide filled in by 4 Homicide Continying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 29e. Certifier completaly Ical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. (Check only one) 29d. Date signed (Month) Day, Year) 29c License number 29b. Signature and title 30. Neme and address of persen who completed cause of deeth (Item 23e) (Type, Print) 500 Bonlevara 15m 32. Registr 31. Dete filed (Month, Day, Year) JAN 26 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Pate of Deeth **Physician** onnoll /Medical 4e. Fecility Name (If not institution, give street end number, 4b. City, Town, r Location of Death Examiner N JOSEPH RITCHEY HOSPICE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. Birthplece (State or Foreign Country) **Funeral** 1□M 2₩F 160-24-3000 86 Yrs. Director OCT 19, 1911 PENNSYLVANIA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. tnside City Limits Director 1 Yes 2 No MARYLAND BALTIMORE CATONSVILLE 10e. Street end Number ALL SAINTS CONVENT 10f. Zip Code 10g. Citizen of Whet Country? 21228 U.S.A. Funeral 1501 HILTON AVENUE 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours efter nent of Heelth end Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed th end Mental Hygiene.

7 is marked other than "natur traumatic evant, the Medical 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EPISCOPAL CONVENT RELIGIOUS SISTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be ELIZABETH A. PERRY JOHN J. CONNOLLY 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) : If item 27 is r ALL SAINTS CONVENT CATHERINE GRACE, MOTHER SUPERIOR 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1/22/98 CATONSVILLE, MARYLAND ALL SAINTS CEMETERY 21. Signature of Funeral Service 22. Name end Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Cartinoung shysician and the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? been signed by should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of the Alaboran type somile orach Records. þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Hypothyridis-After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital All Director: After this cerum. or Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospie 1 Yes 2 No Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) e B. Jim, M.D. 202175 1-19-49

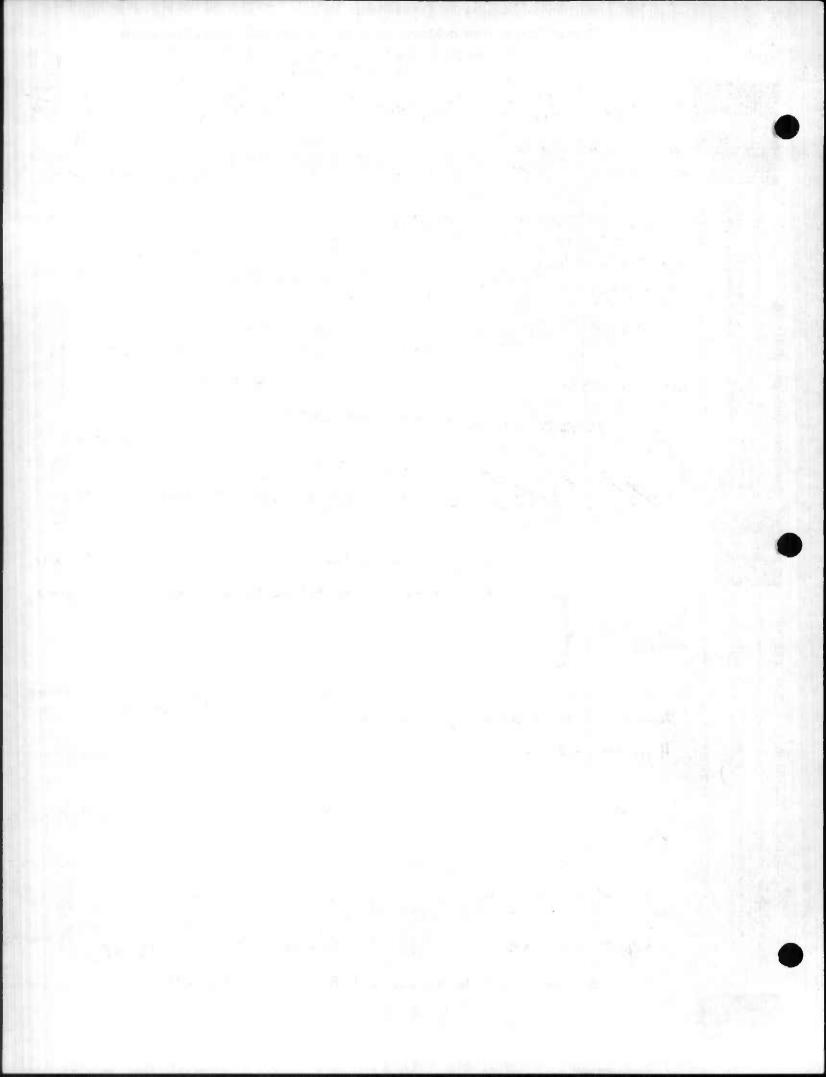
State Registrar 31. Date filed (Month, Dey, Year)
JAN 26 1998
32. Pegistre

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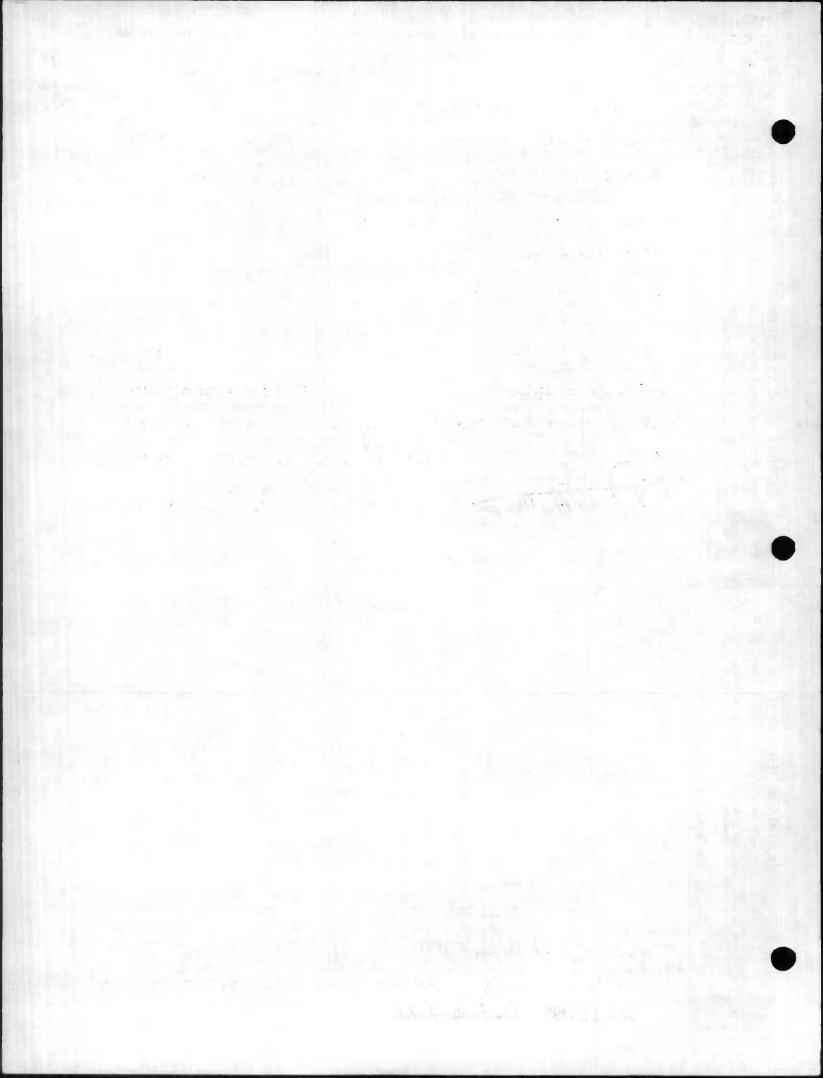
30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

8824 Winado Rocal, Randellofoma. MD 2113>
32. Degistrers signature

Syria Davidson-Randelle



B.K.S			Please 7	Type or P	rint In	Black In	delib	le Ink	. Assure A	All Copies	Are Legi	ble.		
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Physi /Med		KARES			Y-NICC	OLE	CI	INE		Month JAN.	9, Day 1998	Year	1528	
Exam		4a Facility Name (If not PENINSULA							4b. City, Town, or SALISBUE			of Death		
Funera	1	5. Social Security Numb				. last birthday)		er 1 Year	If Under 24 Hrs	8. Date of B		9. Birthple	ace (State or F	Foreign
Directo		221-64-227 Usual Residence of Dec	/1	□M 2⊠F		Yrs.	Months 2	s Days	Hours Min.	10/28/		Count	yland_	
ylend Mon			b. County		10c. Ci	ity, Town or Lo	cation					10	d. Inside City	Limits
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21215-0020 d within 72 hours aft giene. Ir than "natural", or than "a wou cal Exam.	Completed	Elementary/Secondar	ry (0-12)	College (1-4	lor 5+)	Non		use reine	(d)		None			
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Alar and and sum		19e. Informant's Name							and Number or R				Code)	
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Physiciar	,	shock, or heart fa	llure. List only o	ne cause on ea	at line.								Interval Betwe Onset and De	
/Medica Examine		Immediate Cause (Fina disease or condition	al	SUD	DEN INF	ANT DEAT	H SYN	IDROME						
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ted nsit	Examiner	Call Call		b										
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760 ite be ysicie	Cal	Cause (Disease or injust that initiated events		c	Due io (or es a conseq	uence of):						
ords, P.O. Box 68760 requires that the death certificate be seen signed by the attanding physicia hould be dateched for use as the bur	Physician/Medica	resulting in death) Last										- 1		
S, P.O. BOX as that the death cer igned by the attendin be deteched for use	lan/			•,										
P.O.	iysid	Part II. Other significan	t conditions cor	ntributing to dea	th but not res	sulting In the u	nderlying	ceuse gi	ven in Part I.		tobacco use co			
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Records, ha law requiras the hes been signed age 2 should be de										24a. Wa	s an autopsy formed?		re autopsy fine	dings
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Division of Vital or Attending Physician: Taffer death. Director: After this certificat in by the funeral director, p	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined			ome, farm, str	reet, facto	ory, office		28f. Location	(Street and Num!	per or Rura	Route Number	97,
Div	Cert	4 Homicide		building	, etc. (Speci	ny)				City of 1	own, State)			
Division of Vita with the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director.	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	ner: On the bas	is of examina	owledge, deeth ation and/or in	occurre vestigation	d at the ti	me, dete and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and ma e, date and place,	anner as stand due to	ated. the cause(s)	
ithin of the comple	Mec	29b. Signature and title	of certifier	and menne	r stated.		2	9c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)	
6484		1 1/911	als &	In W) no	ght n	ON		O.C	.M.E			10,		
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S Regis	tate trar	31. Date filed (Month, D	1 5 1998	Julia Be	istrar's Sign	Rardall								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 31 Per DVR Film G-755 1-26-98RC 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Yaer JOYCE POZIER JAN 98 6:00 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b City Town, or Location of Deeth 4c. County of Deeth Examiner Balt more MERCY MEDICAL CENTER Baltimore If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2√F 44 Yrs. Director 215-58-1891 1952 MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at N/A BALTO Director 1XX as 2 □ No 10f. Zip Coda 10e. Street end Number 10g. Citizen of What Country? 1201 MIDDLEWAY RD 21220 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify BLACK 3 ☐ Widowed 4 ☑ Divorced Completed Decedant's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiana. Important: If itam 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) Coltege (1-4or 5+) HOSPITAL N/A NURSING ASSISANT 17 Fether's Neme (First Middle Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be ERNEST ROBINSON ROSALIE MURRAY 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) ERNEST ROBINSON JR 2618 BERYL AVE BALTO, MD 21205 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete JAN 23 ARBUTUS MEM PK 5 ☐ Other (Specify) 1998 BALTIMORE, MD 21. Signature of Funerel Service License 22. Name and Addrass of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 uda 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dylng, such es cardiac or respiretory errest, shock, or haart feilure. List only one cause on each lina. **Physician** /Medical Immediate Ceuse (Final disease or condition rasulting in daath) SEVERE CARDIONYOPATHY Examiner Due to (or es e consaquance of): Physician/Medical Examiner HEMRT FAILURE PONGESTIVE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in deeth) Lest Due to (or as a consequence of) Hupes Division of Vital Records, P.O. Box 68760, ettending physician DISSEMINATED esn signed by the e Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown aallstons þ 24e. Wes an eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of daeth? Completed peen s page 2 s 200 1 ☐ Yes 2 ☐ 0 certificate 1 🗆 Yes the Hospital or Attending Physician: Thin 24 hours efter death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, the funeral director. 25. Wes casa raferred to medical axaminer? Be 26. Piece of Daeth (Chack only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Deeth 28b. Time of 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dev Yeer) 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Numbar or Rurel Route Number, City or Town, Stete) 4 Homicida Certifying Phyelcien: To the best of my knowledge, death occurred et tha tima, data end plece, end due to the ceuse(s) and mannar as statad.

2 Medical Examiner: On the basis of exemination and/or Invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end mennar statad. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of oil 29d. Date signed (Month, Day, Year)

Baltmore, ND 21201

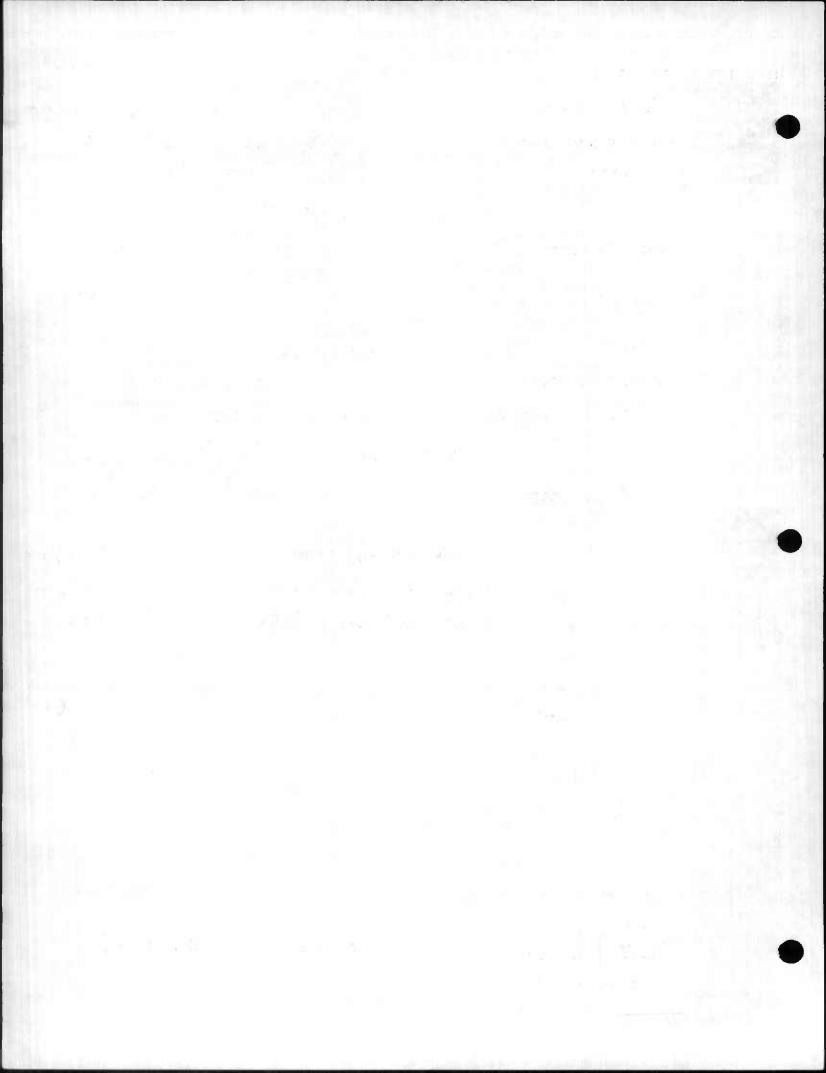
address of parson who complated cause of death (tem 23e) (Type, Print)

22501th GREEN ST

State Registrar JASON BIRNBAUM

filed (Month, Day, Year)

98 JAN 26



Page 6 may be retained by the hospital or attending physician. TIMORE, MARYLAND 21215-0020 the

funeral director, page 5 should be detached for use as the bunial-transit

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DIVISION OF VITAL

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ò	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withir 24 hours after death	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal,
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH Margaret Ann Dietz 6. AGE (In yrs. lest birthday)

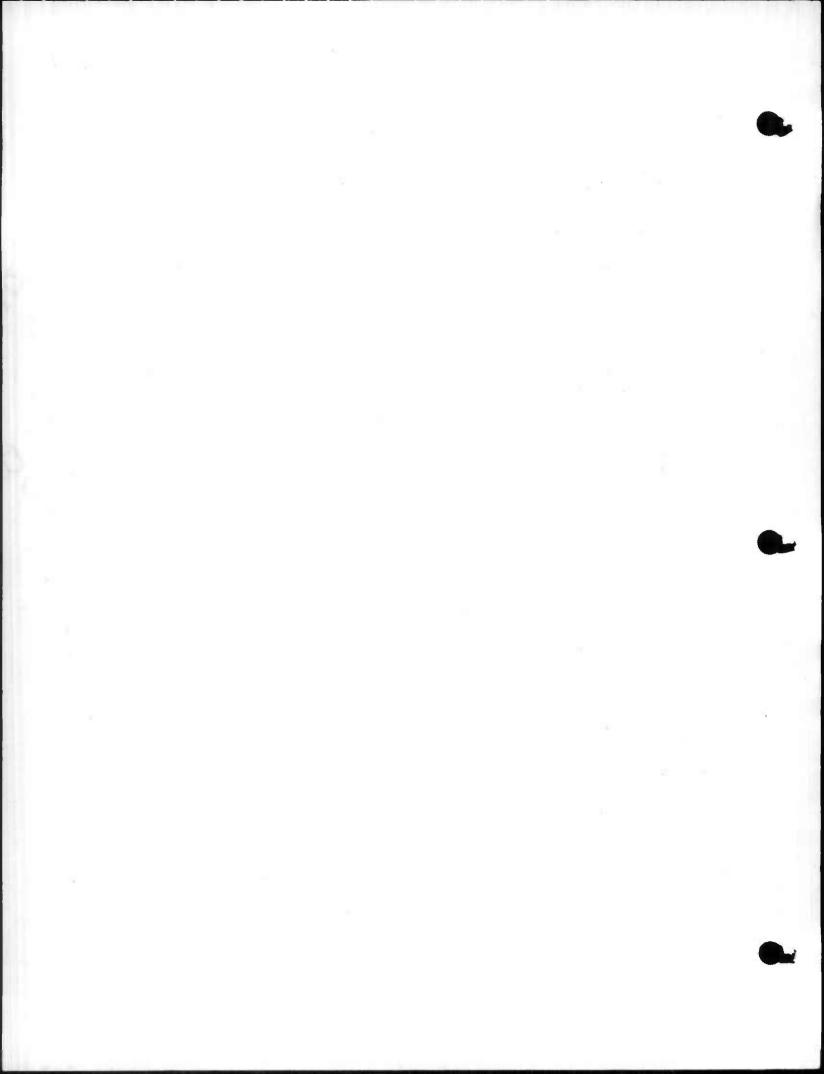
REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1998 January 17 10:30 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
JULY 18, 1914 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-48-9625 HOURS 1 🗌 M 2 💢 F 83 YRS. Maryland 9e. FACILITY NAME (If not Institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 11129 Philadelphia Road DIRECTOR White Marsh Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10h. COUNTY 10d. INSIDE CITY Baltimore Maryland White Marsh 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11129 Philadelphia Road 21162 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicon, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried spectly: White BY 3 💢 Widowed 4 🗌 Divorced 16e. DECEDENT'S USUAL OCCUPATION

173 Inm. kind of work done during most of working BE COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph Heindl Margaret B. Smith 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Mary Dietz (dghtr) 11129 Philadelphia Rd.. White Marsh, MD 20a, METHOD OF DISPOSITION
1 A Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Holly Hill Memorial Park 1/20 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY Schumuner Funeral Homes, Inc. aborn Tobust 9705 Belair Rd., Baltimore, MD 21236 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death RENAL disease or condition CUTE FAILURE WEEK resulting in death) DUE TO (OR AS A CONSEQUENCE OF): EHYDRATION CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING ALNUTRITION CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL RYOGIOBULINEM IA 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 □ Nursing Home 5X Residence 6 □ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO Investigation 2 Accident
3 Suicide 28e. PLACE OF tNJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner on stated. (Check only one) mination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ea stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) JANUARY 18, 1998 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WALLACE BRIAN BELDIR, ROAD 6801 BATIMARE, MO 21206

31. DATE FILED (Month, Day, JAN 26

DHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 21, 1998 6:00 AM MARY FRANCES DEGUTIS January 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Baltimore Reisterstown 502 Owings Ave. If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) Months Deys 1□ M 2☑ F Yrs 214-24-0153 Usuel Residence of Decedent 79 Apr 9, 1918 Ohio 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Reisterstown 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code **USA** 502 Owings Ave. 21136 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian, Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2₺ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etementary/Secondery (0-12) Prince Cotlege (1-4or 5+) 8 years Contracting Co. Contractor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Goy Williams Sophronia Childers 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn Prince (Daughter in law) 502 Owings Ave. Reisterstown, MD 21136 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1⊠ Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Memorial Park 1-23-98 Middle River, MD 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Loring Byers Funeral Directors, Inc. 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. 8728 Liberty Rd. Randallstown, MD 21133 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting to deeth) Due to (or es e consequence of): Due to (or es e consequence of) Due to (or es e consequence of):

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The lew requires that the death certificate be executed

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Division of Vital Records,

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rai", or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vient of states and Mental Hygiene.
Int: If item 27 is marked or ther than "natural, or thems 23 inty or other traumatic event, the legals Eventh matter.

Baltimore, Maryland 21215-0020

Director

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Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or trijury that initieted events resulting in deeth) Lest Physician/Medical

Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 2, X No 1 ☐ Yes 1 □ Yes 2 □ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2□ Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

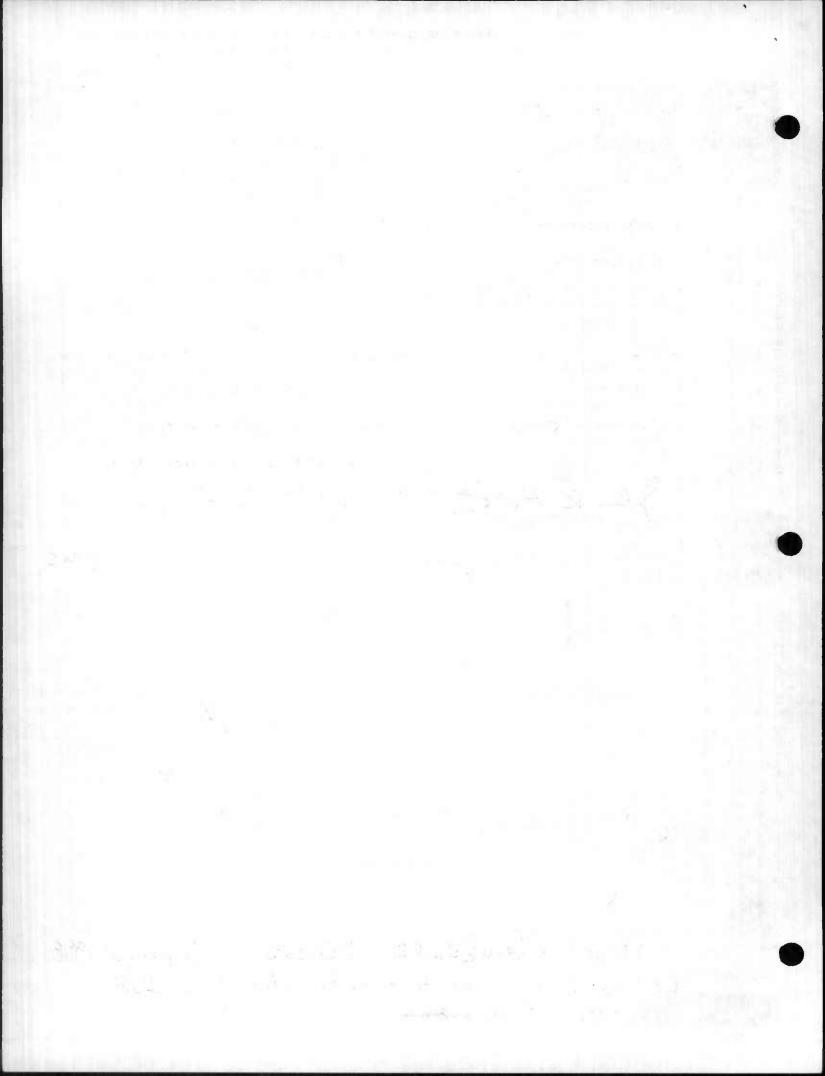
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Print) 30. Name end eddress of person who completed cause of de

DeesMD 600 N. 32. Registrar's Signature 31. Dete filed (Month, Day, Year)

State Registrar

26



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month JANUARY 23, William Henry Donaldson III 1998 15:08 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner N/A SAINT AGNES HOSPITAL, 900 CATON AVENUE BALTIMORE H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

April 10, 1950 5. Sociel Security Number 6. Sex 1☐M 2☐ F 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 213-52-2723 Director Maryland Usual Residenca ot Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Lansdowne Maryland 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 236 2nd Avenue 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Henry Donaldson Jr. Gloria Loretta Asberey 19e. Interment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anita Donaldson, wife 236 2nd Avenue Lansdowne, Maryland 21227 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □XBurial 2 □ Cremation 3 □ Removel trom Stete permit. Pege Department of Important: If any injury or once. 1/28/98 Glen Haven Cemetery Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Maryland 21227 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) tarction Examiner Due to (or es e consequenca of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown high Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? evoted 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? 86 26. Place of Deeth (Check only one) examiner / 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Naturai 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.

2 Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated.

29c. License number

gnes Healthcare

29d. Dete signed (Month, Dey, Yeer)

28a-f show

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Items 23a

"natural", or

Peges 1 and 2 should be filed within in nent of Health end Mental Hygiene. Int: If Item 27 Is marked other than "rury or other traumatic event, are Heal ary or other traumatic event, are Med

72 hours after

21215-0020

Baltimore, Maryland

traumatic event, the Medical Examiner must be notified at

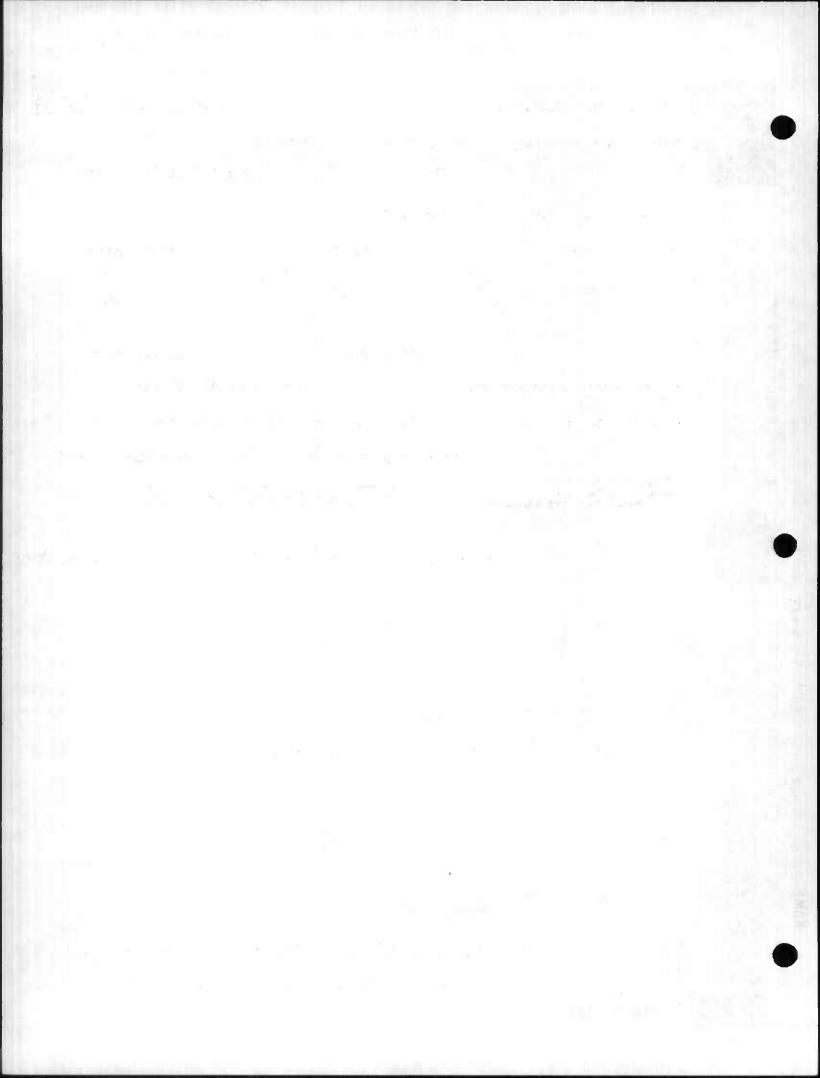
State Registrar

31. Date filed (Month, Day, Yeer)

29b. Signeture and title of cartifier

DHMH 16 Rev 6/95

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Thomas George Dobry Jan. 16, 1998 2:20 A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours Director -09-3498 87 Aug. 17, 1910 Pennsylvania the Maryland 10a State 10h County 10c. City, Town or Location permit Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Heelth end Mental Hygiene. Important if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Directo **Dundalk** MD . 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 225 Colgate Avenue 21222 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes \$\frac{1}{2} D No If Yes, Give Yeer or Detes: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Never Married 25 Marriad 1 ☐ Yes 2 ☑ No Specify: Specify: WHite þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Supervisor Steel Company 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 UNK. 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Regina Dobry / Wife 225 Colgate Ave. Baltimore, MD 21222 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ② Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Washington Crematory 1-18-98 Laurel, Maryland 21. Signature of Funeral Sector Licens 22. Name end Address of Fecility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 WILLOW Spring Road, Paltimore, Maryland 21222
Appropriate on each line. Onsel end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition rasulting in death) decade Examiner Due to (or es e consequence of) Examiner 1 abetes Melle ettending physician end for use es the bunel-transit certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events Due to (or es e consequença of) Physician/Medical Due to (or es e consequence of): rasulting in death) Lest Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown signed by 1 ☐ Yes 2 ☐ No by 24b. Ware eutopsy findings eveileble prior to complation of cause of daath? 24e. Wes en eutopsy Completed page 2 certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA P 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: After Natural 2 Accident 5 Panding investigation 1 ☐ Yes 2 ☐ No 3 Suicide

Box 68760. P.O. Records, Division of Vital Attending after death.
Director: After in by the fur 56

Baltimore, Maryland 21215-0020

6 Could not be

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Balto

1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete and plece, end dua to tha causa(s) end manner es stated.
2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, daath occurred et tha time, data end place, and dua to tha ceusa(s) end menner steted. 29b. Signature end title of cartillo

4 Homicide

29a. Certifier

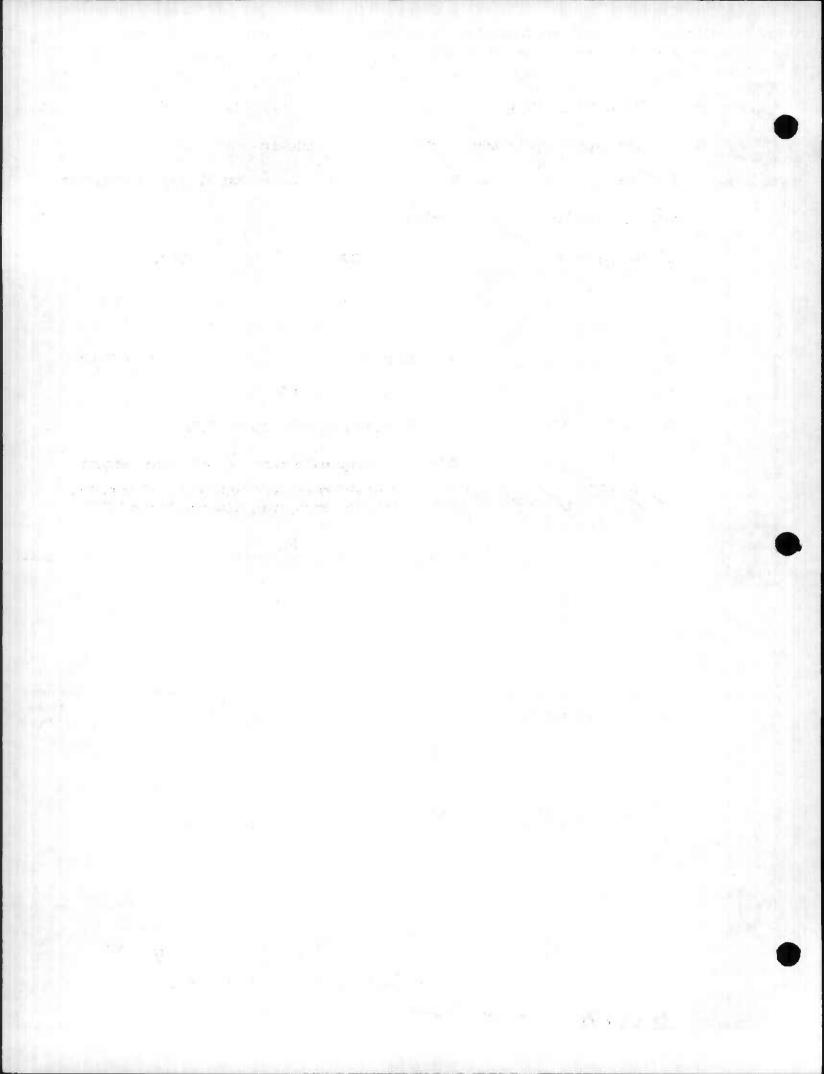
29c. License number

29d. Date signed (Month, Dav. Yeer)

ess of parson who complated causa of daath (Itam 23a) (Type, Print) 30. Nema end addre Blud-Suite 700

Jania Ryden W 31. Date filed (Month, Day, Year) 1005 No. Point no

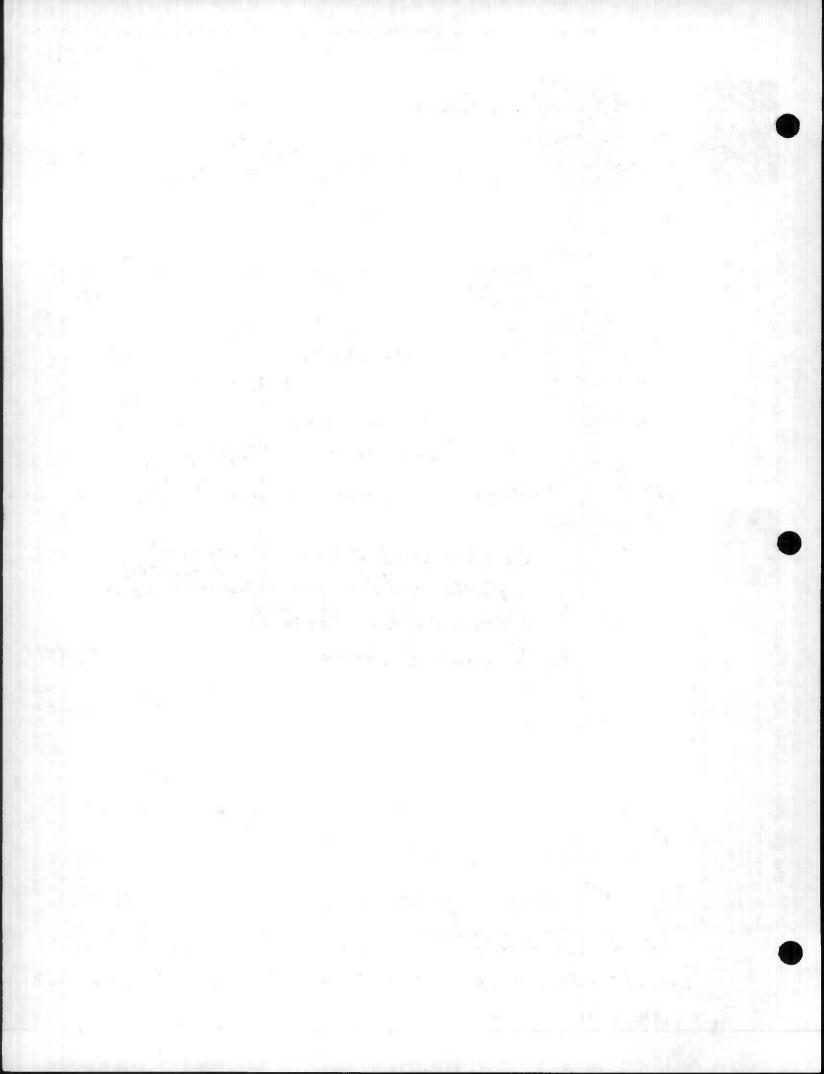
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene O

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Baltimo permit. Pag Department Important: 1	once.	000	21. Signature of Funeral Sarvice	a Licansee	6			drass of Facility B		NERAL H		213
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Box 6 eath certification of the second of th	an/			d		1	1				- '	
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Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Affer th	edical			ing Phyaicien: To the it Exeminar: On the and ma								
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5			30. Name end eddrass of perso	n who complated ca	use of death (Its	m 23e) (Type, Pr	rint) NAOT	WE DAT PA	Lekumy	Ba No	14	1) 21214
	State		31. Dete filed (Month, Day, Yea	1) 101/11/14	Ragistrar's Sign	natura	HUKI	YEKM IN	KI-CIII)	1	11	121011
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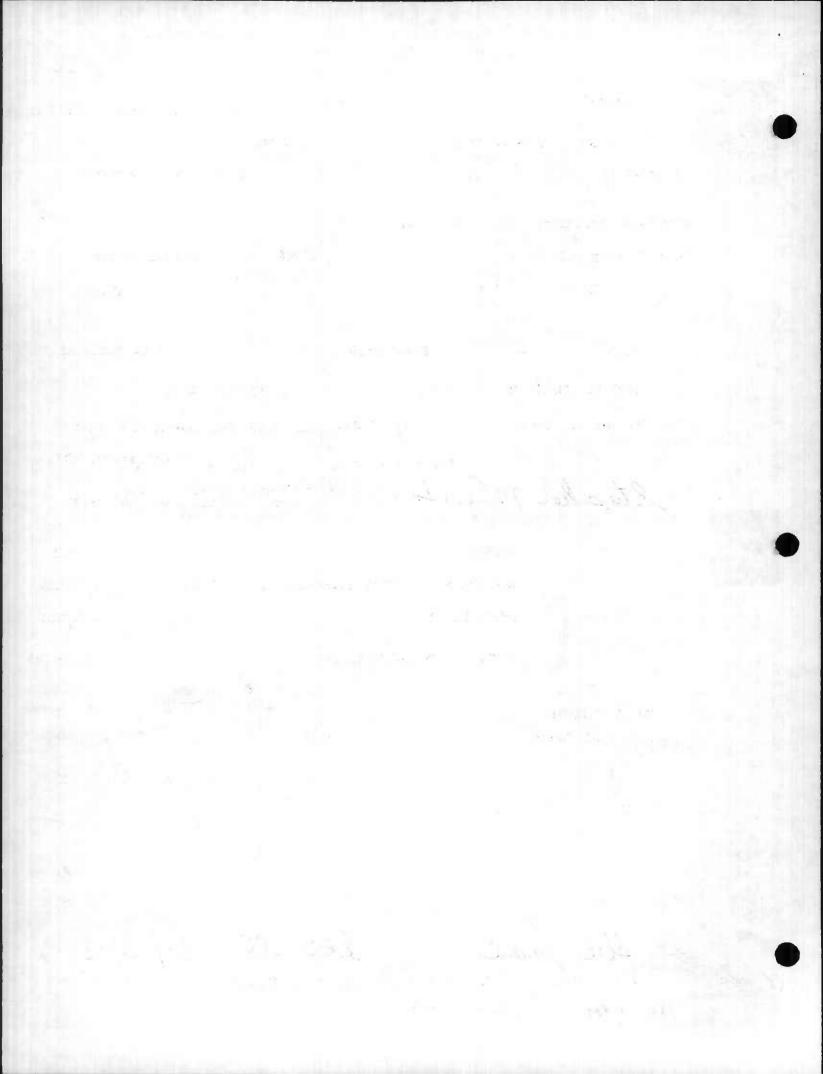


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** MARGARET **EVANS** 25 JANUARY 1998 12:54 am /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 11/14/1930 9. Birthplace (State or Foreign Country)
Maryland 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Yrs. Director 215-28-0773 67 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner nast be notified 1 Yes 2 No Director Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö death with 8216 Windsor Mill Road items 23a 21244 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Maritel Status 72 hours after 1 Never Married 2 Married 21215-0020 White "natural", or 1□ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) B. & O. Railroad Stenographer Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event sonce. 18. Mother's Name (First, Middle, Maiden Surname) Be Carl W. Ehrhardt Minna Gompf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streef and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William A. Evans 8216 Windsor Mill Road Baltimore, MD 20a. Melhod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Locetion - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Mount Olive Cem. Jan 29 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8782 Liberty Road Randallstown, MD 21133 23e. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each ine. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS 3 DAYS disease or condition resulting in death) **Examiner** Due to (or es e consequence of): VANCOMYCIN RESISTANT ENTEROCOCCUS INFECTION Examiner 2 WEEKS The law requires that the death certificete be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): NEUTROPENIA 1 MONTH P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): 98 ACUTE MYELOGENOUS LEUKEMIA 2-3 MONTHS attending esn 10 been signed by the a should be detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE Records, ò ABDOMINAL SURGERY 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital of the Hospital or Attending Physician: ithin 24 hours after death. Othe Funeral Director: After this certifies omberely filled in by the funeral director, 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCartifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner steted. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allow 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 12 ALIX LANOUE M.D. 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

State Registrar 31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21,1998 Month **Physician** RUBY L. EGOLF January 7:40 F.M. /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Carroll Westminster if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Days 1 M 2 F 88 Franklin CO. Pa Yrs. 214-12-8071 Director Nov. 25, 1909 Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show Examiner neat be notified at Baltimore Reisterstown 1 ☐ Yes 2 No Director Md. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 items 23e USA 4 Austin Road 21136 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Biack, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No if Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 ☐ No Specify: White by Specify: 3 XWidowed 4 □ Divorcad Completed event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry be filed within 7 lal Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 2 Yrs. College Balto. Co. School Board Teacher permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: if item 27 is merked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Ambrose C. Elliott Bessie M. Burkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Centreville, Md. 21617 1610 John Brown Rd. Kenneth W . Egolf (Son) 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27/98 Evergreen Memorial Finksburg, Md. 21. Signature of Funeral Service Licansee 22. Name end Address of Facility 11824 Reisterstown Road line ELINE FUNERAL HOME Reisterstown, Md.21136 234 Pul 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whick, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician /Medical date Cause (Final ONSUMONIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): physician 68760 Physician/Medical 2 Due to (or es e consequence of): Box 289 ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? o 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chranic DISTINCTUS PULMOUNT DISTING À Records. sign d b 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen DEMENTIA page 2 1 Yes ≥ No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural

Accident 5 ☐ Pending n 24 hours after death.

• Funarel Director: After pletaly filled in by tha fur investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospitai 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completaly (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DX17040 01-22-98

M.D. 2]5 Wahington Hgts Med. Cen, Westminster 2]]57

Registrar

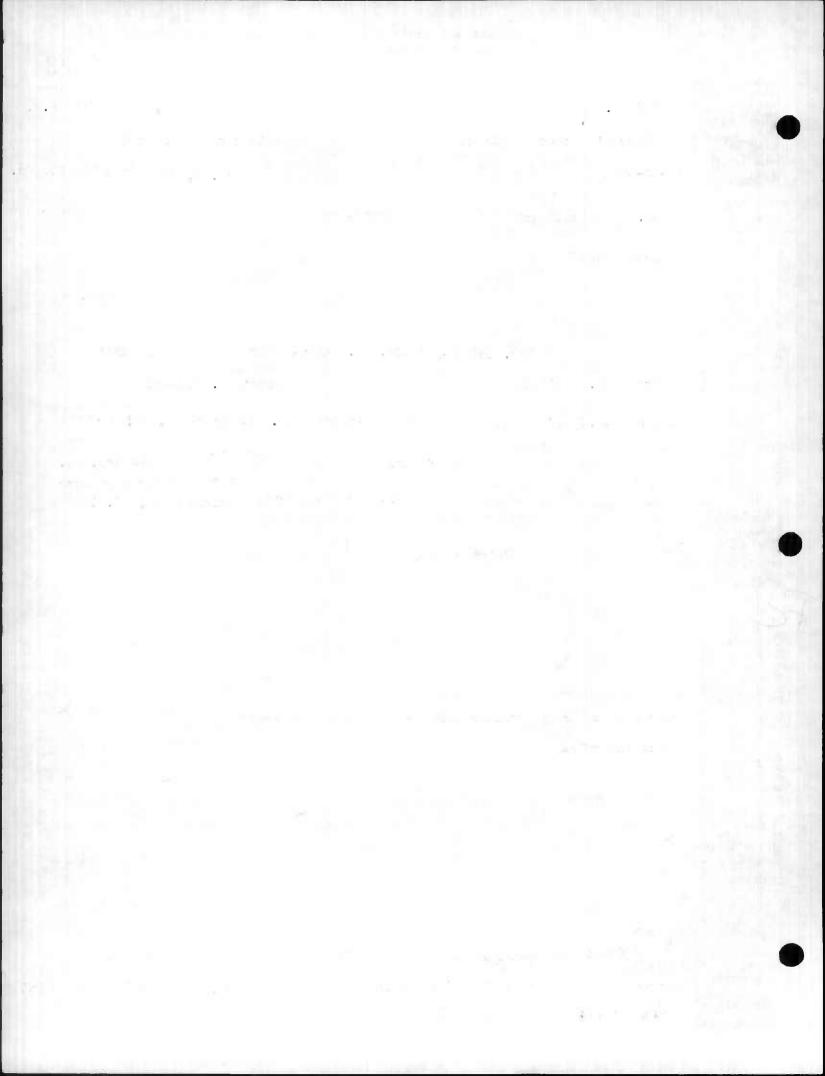
State

Howard G. Lanham,

31. Date filed (Month, Day, Year)

JAN 26

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Physici Medic		1. Decedent'e Neme	(First, Middle,	Last)			Certificate o		2. Dete of De			3. Time of Death
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DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Lest) 2. Dete of Death Jan. 22, 1998 Katherine 9:15 p.m. Famulari 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare 9109 Liberty Road Randallstown Baltimore 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dev. Year) Nov. 27, 1913 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months 1 M 2 F 019-14-6605 84 Yrs Massachusetts Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Owings Mills 1 ☐ Yes 2 XNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 1120 Kingsbury Road 21117 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Factory Worker Textile 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Korney Onchick Paraska Junka 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 1120 Kingsbury Rd., Owings Mills, Md. 21117 John A. Famulari 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State Woodlawn Cemetery Jan. 27,1998 Everett, Massachusetts 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21117 Eckhardt Funeral Chapel 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Approximate Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) · PROBABLE MYOCARDIAL INFARCTION 2 5 Mary Due to (or es e consequence of) CORONARY ARTERY DISEASE 23040 Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or as e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown ATRIAL FIBRILLATION, HYPOTHYROIDISM 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en autopsy 1□ Yes 2 No 1 Yes 2 No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23e

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72 hours efter

Saltimore, Maryland 21215-0020

Director

Funeral

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Completed

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traumatic event, the Medical Examiner nunt be notified at

bunal-tran attending physician for use es the buna Hoepital or Attending Physician:
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 Funeral Director: After this certifical

Records, P.O. Box 68760

Division of Vital

Physician/Medical Examiner Completed 8 Certification: To à

completely To the Within 2

State Registrar

Medical

25. Wes case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D40390 ATTENDING PHYXCIAN

JAN. 23, 1998

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) 5310 OLD COURT RD #305, RAND ALLSTOWN, NO 21133 PANKAS A. DESALMO. 31. Date filed (Month, Day, Year)

JAN 26 1998

Julia Vavidson Ronde 12

41-21-14 step because the commence of t AND PRINCIPAL OF THE RESPECTATION OF THE RESPE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 31 Per DVR FilmGG-755 1=26-98RC State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** Year 13 1998 8:30 A.M. /Medical Jan 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 437 Shady Lane Pasadena Anne Arundel If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Sacurity Number 6. Sax If Undar 1 Yeer 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Yrs Director 215-05-1983 82 7, 1915 Maryland Usual Rasidanca of Decedant the Maryland 10a State 10b. County Show 10c. City, Town or Location 10d. Insida City Limits rai', or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e Street end Number 10f. Zip Code 10g. Citizan of What Country? 437 Shady Lane 21122 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaer or Detes: 'natural', or items 11. Maritel Status Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours efter 1 ☐ Navar Married 2 ☑ Married 1 ☐ Yas ZX No Specify: þ Specify 3 Widowed 4 Divorced White Completed The Medical 15. Dacadant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) filed within Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Baltimore County 12 School Bus Driver Board of Education 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Peges 1 and 2 should be 1 nent of Health end Mental Elmer 2 Cofiel1

20b. Placa of Disposition (Nama of camatary, crematory or other placa)

23a. Pert1. Enter the disease, or complications thet baused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

New Oakland Cemetery

Physician /Medical Examiner

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24 hours after deat Funerel Director:

within 2 To the å

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Department of Health elimportant: if item 27 is any injury or other training.

19a. Informant's Name/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Othar (Spacify)

21. Signature of Funaral Sarvice Licensaa

20a. Mathod of Disposition

Immadiata Cause (Final disaasa or condition rasulting in death)

29b. Signature and title of certifie

Mr. Merle C. Greenwalt, Sr.

1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State

Saltimore, Maryland 21215-0020

sician end buriel-transit the 98 for ete has been signed by the epege 2 should be detached director

The law requires that the death certificate be executed

68760

Box (

P.O. |

Records,

of Vital

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Arending Physician:

Hospital or

Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Diseasa or Injury that initiated avents rasulting in daath) Last Physician/Medical Due to (or es e consaguança of Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed 25. Was case refarred to madical Be 26. Placa of Death (Check only one) axaminar? 2 No Othar: 4 1 Certification: To 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 5 Pending invastigation 1 ☐ Yes 2[2 Accident 6 Could not be datarminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homleide 29a. Cartiflar Medical (Check only one)

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No

20c. Location - City or Town, Steta

21133

Approximata Interval Betw Onsat and Death

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21122

Randallstown, MD

Vursing	Homa 5 Rasidenca 6 □Other (Specify)
□No	28d. Dascribe how injury occurred
	28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

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2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Qay, Year)

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19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

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Loring Byers Funeral Directors, Inc.

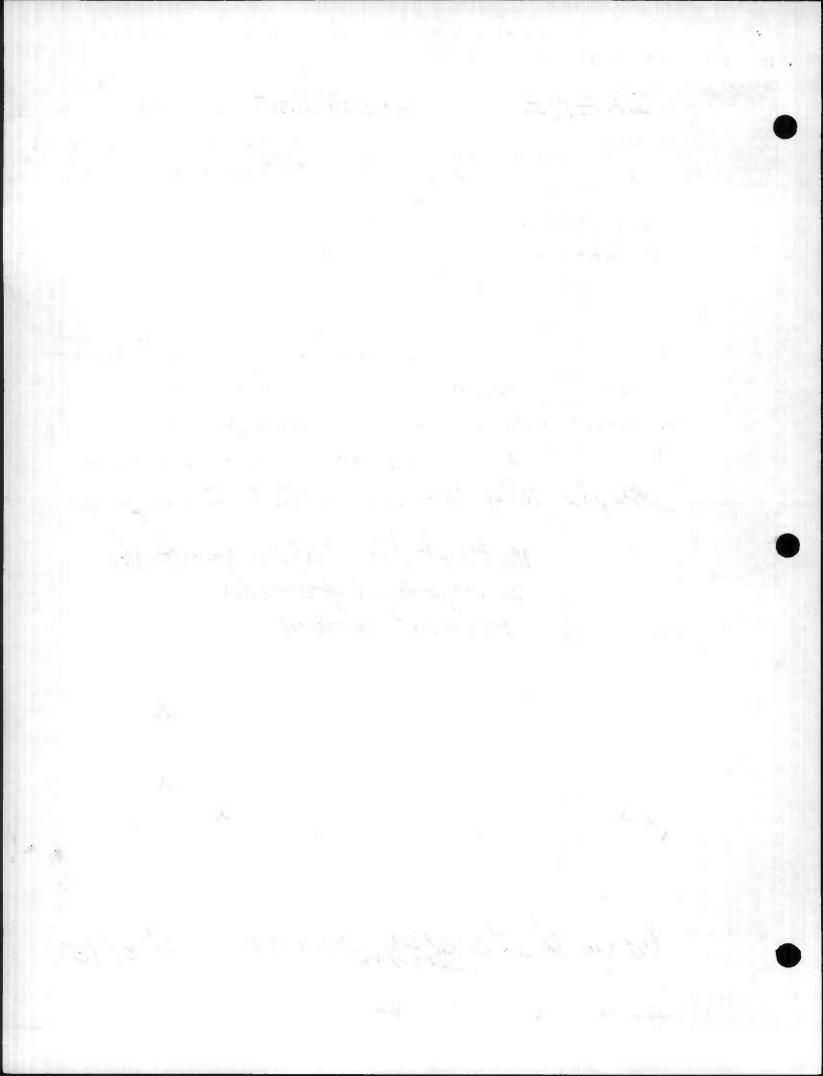
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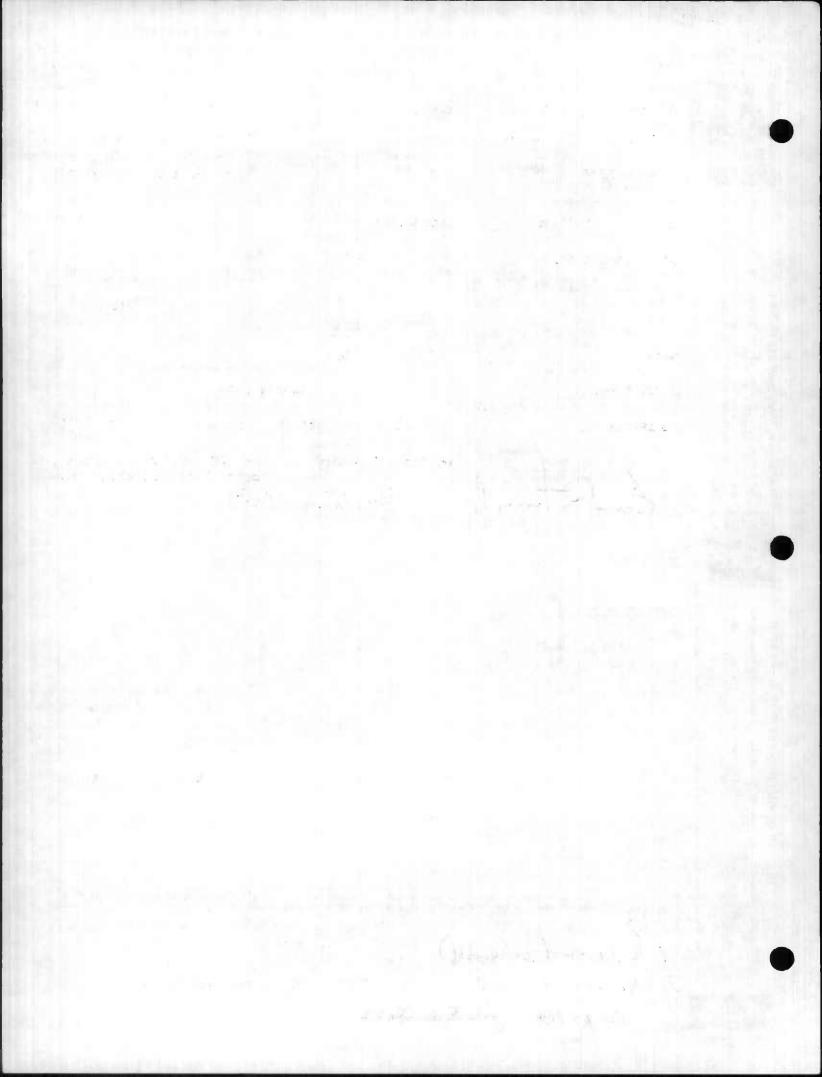
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UDAVA BHA 1600 Crain Highway Suite 408 Glen Bense 31. Date filed (Month, Day, Year)

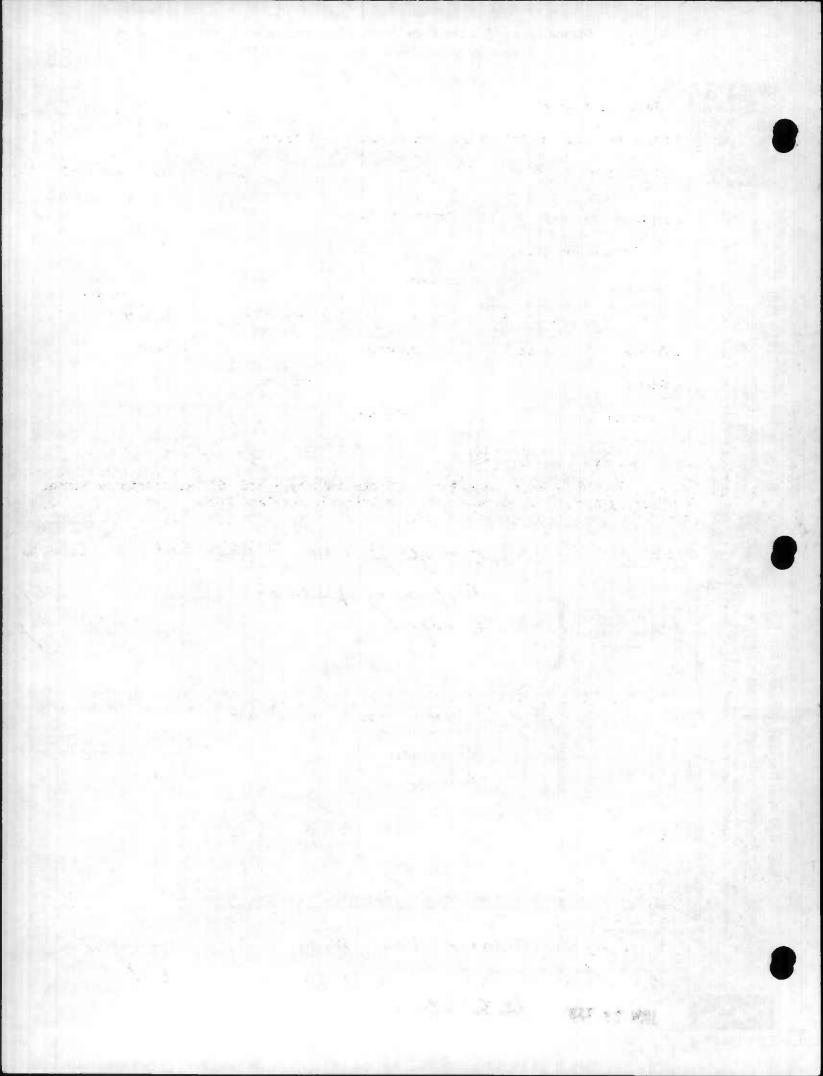
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	/Medical Examiner		Immediate Cause (diseese or condition	n	ASTHM.	A							
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	that if									1	Yes 2 No	3 Pro	bably 4 Unknown
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ita	yeiclen: The lav s certificete hes director, page 2	3 2	25. Wes case refer exeminer?	red to medical					26. Place of	Death (Check only	one)		
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n C	Ing P	2	 Manner of Deat Deat 	5 Pending	28e. Dete of Inju (Month, De	y Year)	28b. Time of Injury	V		28d. Describe	how injury occur	red	
Division	or Attending I offer death. Director: After I in by the funer		2 Accident 3 Suicide	investigetion 6 Could not be	28e. Plece of Inj	ury - At he	ome ferm str		Yes 2 No	28f. Location	(Street end Numi	er or Rur	rel Route Number,
S.	tel or Attending P rs efter deeth. al Director: After t led in by the funer		4 Homicide	determined	building, et	c. (Specify	y)	001, 1001019, 01111			wn, Stete)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:		29a. Certifier (Cheek only	1☐ Cartifying Phys									
	in 24 hours the Funeraples fill appletely fill		one)	XX Medical Exami	end menner st		tion end/or in			occurred et the time			
	With To the Common	2	29b. Signature and	title of certifier	0				c.M.E		29d. Date signe		
			()	wort	orled	M			C.P.E		JAN. 2	.Z, I	770
		3	i A O	ess of person who co	ompleted cause of c				Pal+i-	nore, Mar	uland 21	201	
	State	3	31. Dete filed (Mon	th, Day, Year)	32. Registr	er's Signe	ture		r, parth	iore, Mar	ATORIO SI	.201	
	Registrar			N 26 199	J. A.	David	bon-Ran	tell					



		1. Decedent's Name (First, Middle, L	Last)		2011	tificate of		2. Dete of D			3. Time of Dea		
Physicia	_	James B. Hodge	es					Month	Dey	Year 1999	2 02		
/Medica Examina	_	4a Facility Neme (If not institution, g		ər)	<u></u>		4b. City, Town, o			ounty of Deal	h		
LX	٠,	Lorien Nursing a	and Rehabi	litatio	n Cen	iter	Belcamp		NA	RFORT			
Funeral Director		5. Social Security Number 213-22-0544 6.		Age (In yrs. lesi 79	t birthday) Yrs.	If Under 1 Year Months Deys			irth ley, Yeer)	9. Birt) hplece (Stete or Fo puntry) ryland		
2 >		Usual Residence of Decedent 10a. State 10b. County		100 City T	Town or Loc	ention					10d. inside City Li		
show	5	Maryland Harfor	-d	7		Grace					1 ☐ Yes 2 ½		
28a-f sho	Director	10e. Street end Number	. u			10f. Zip Code			10g Chiza	on of What Co	4-1-1		
23e or		100 Revolution				21078				n of Whet Co			
o'la	by Funeral	11. Marital Status 1 ★Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceder Armed Forces 1 Yes 2 ff Yes, Give Year or Dates	s? unkno □No	wn If	/as Decedent of Nes, specify Cub ☐ Yes 2 No	an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		I. Raca - Ame Black, Whit pecify: W			
natural'	Completed	15. Decedent's I (Specify only highest g	Education grede completed)	1	16e. Decede	ent's Usuel Occup kind of work done O NOT use retire	pation during most of w	orking	16b. Kind of Business/Industry				
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il Hygiel other ti		unknown			diikiio	WIL	10 Mathada M	eme (First, Middle					
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nent of Health and: If item 27 is iny or other train		20e. Method of Disposition 1 Burial 2 Cremetion 3		te cem	e of Dispos etery, crem	ition (Neme of etory or other ple	ice)	Dete	20c. Loc	ation - City or	Town, State		
tant		4 Donetion 5 MOther (Spec									4		
Department of Pimportant: If ite any Injury or of pince.		21. Signature of Fyneral Service Lice Ronald S.	Wade, Dir	rector		Name end Addre tate Ana altimore				ltimor	e Street		
		23a. Perti. Enter the disease, or co	mplications that caus	sed the deeth.							Approximate interval Between		
hýsician		23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Immediate Ceuse (Finel disease or condition Osleolytic alice Mass & Metas tasks											
/Medical													
xaminer		resulting in death)	θ	Due to (of e									
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and I-trans	Kam	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	0.	Due to (or e	s e consequ	erica off.							
physician and s the bunal-transit	edical Examiner	cause. Enter Underlying Ceuse (Disease or tnjury	c	ence	halo	helly				-54	Two d		
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hes 3e 2	d L	Chroner obstructive Pu. Disease 1 Yes 2 No Dement 2 Blindness 24e. Wes an autopsy performed?									of death?		
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	tion	1 Natural 5 Pending investigati	28e. Date of Ir (Month, L	Dey Year)	Injury	28c. Inju Wo	rk?]Yes 2□No						
h. After funer	fica	3 Suicide 8 □ Could not	be 28e. Place of I	Injury - At home	e, ferm, stre	et, fectory, offica		28f. Location	(Street end	Number or R	ure/ Route Number		
death. ctor: After y the fune	F	4 Homicide	building,	etc. (Specify)		7,		City or T	own, State)				
after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be deteched for use e	Certific	29a. Certifier (Check only (Ch											
A bours after death. Funeral Director: After tely filled in by the fune	Ilcai Cer	(Check only 2 Medical Exa											
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within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Σ	one) 2 Medical Exe	end menner	A A-	Pal /Tupa E	np D4	315	7777	1	- 20-			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Yaar **Physician** Month Harris ENG January 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City NA Hospital General 1 laryland If Undar 24 Hrs. 8. Data of Birth 7. Aga (In yrs. last birthday).
93 Yrs. 5. Social Security Numbar If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 1□M 20 F Days 220-30-1191 Director Usual Rasidance of Dacedant 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, the Mod call Examine I must be notified at any injury or other thaumatic event, the Mod call Examine I must be notified at Md NA Baltimore 1 Tas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? FIZU Hollu 14. Race - Amarican Indian, Biack, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 □ Yas 2 □ No If Yes, Giva Yaar or Datas: 1 Navar Marriad 2 Marriad 1 Yas 2 No Specify. À lack 3 Nidowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) URSE NA ivate 12+4 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Basker Sall LICU James 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Floral Route Number, City or Town, Stata, Zip Coda) Salto. Md 1027 N. Carey St. 201N30N - NIECE MIREN 20a. Mathod of Disposition
1 ☑ Surial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 1.28 98 4 ☐ Donation 5 ☐ Othar (Specify) rar 21. Signatura Funarai Sarvica Licensae mare Aur. 21215 4300 Wabash entar tha district a, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or heer failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Final diseesa or condition resulting in death) Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avanfs rasulting in daath) Lasf physician the buria Box 68760 Physician/Medical ä 997 ed by the a Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 Hinknown by 8 24b. Wara autopsy findings available prior fo completion of causa of death? 24a. Was an autopsy performed? Completed has page 2 1 ☐ Yas 2 1 No 1 TYAS 2 TNO certificate 25. Was casa rafarrad to medical exeminar? 26. Placa of Daath (Chack only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 쿭 28a. Data of Injury (Month, Day Yaar) 27. Menner of Death 28d. Dascribe how Injury occurred 28b. Tima of Certification: 28c. Injury at Work? at or Attending P after death. Director: After Affer 1 Matural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital of within 24 hours a To the Funeral D 29a. Cartifiar 12 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stetad. 29b. Signatura and fitta of certifiar 29c. Licansa numbar 29d. Dafa signed (Month, Day, Year)

State Registrar KOM

Lourdes

31. Date filed (Month, Day, Year) AN 26 1998

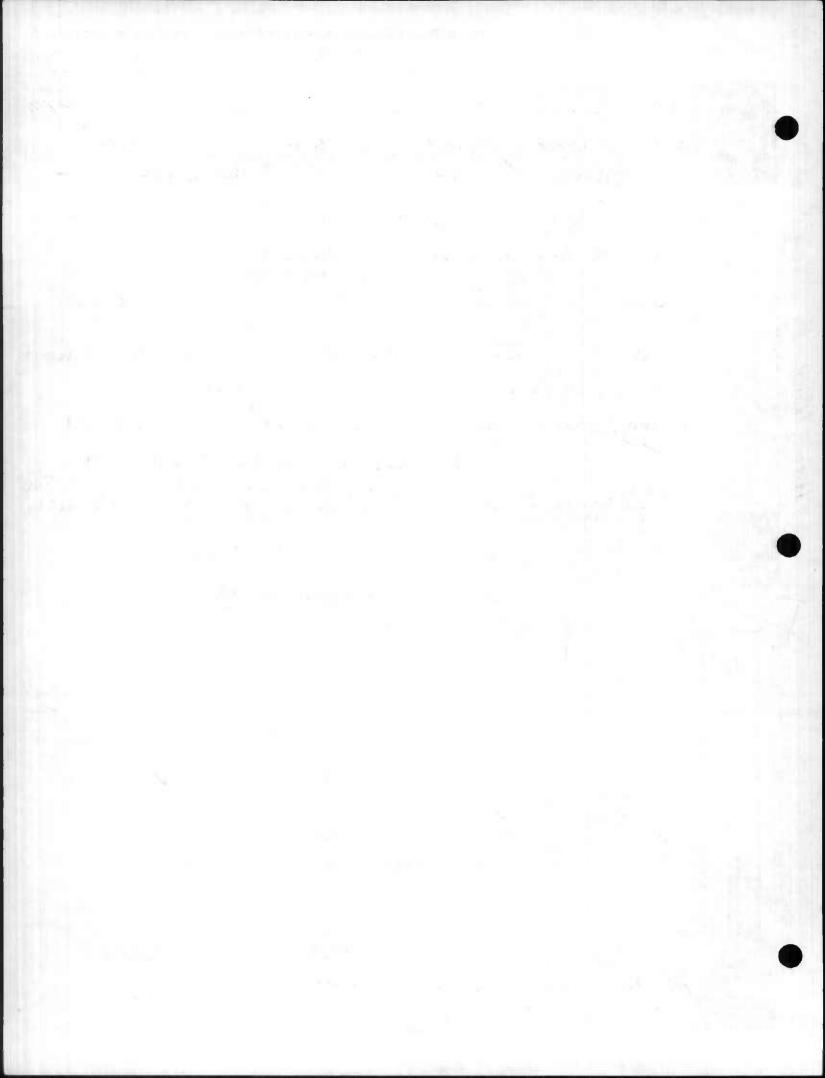
30. Nama and address of person who completed cause of death (Itam 23e) (Typa, Print)

ecilia

Guina, M.D.

32. Registrar's Signatura

To Maryland General Hospital



Registrar

29b. Signature end title of certifier

26

30. Name and eddress of person who completed cause of such (Item 23e) (Type, Print)

2 Dividson Randalle

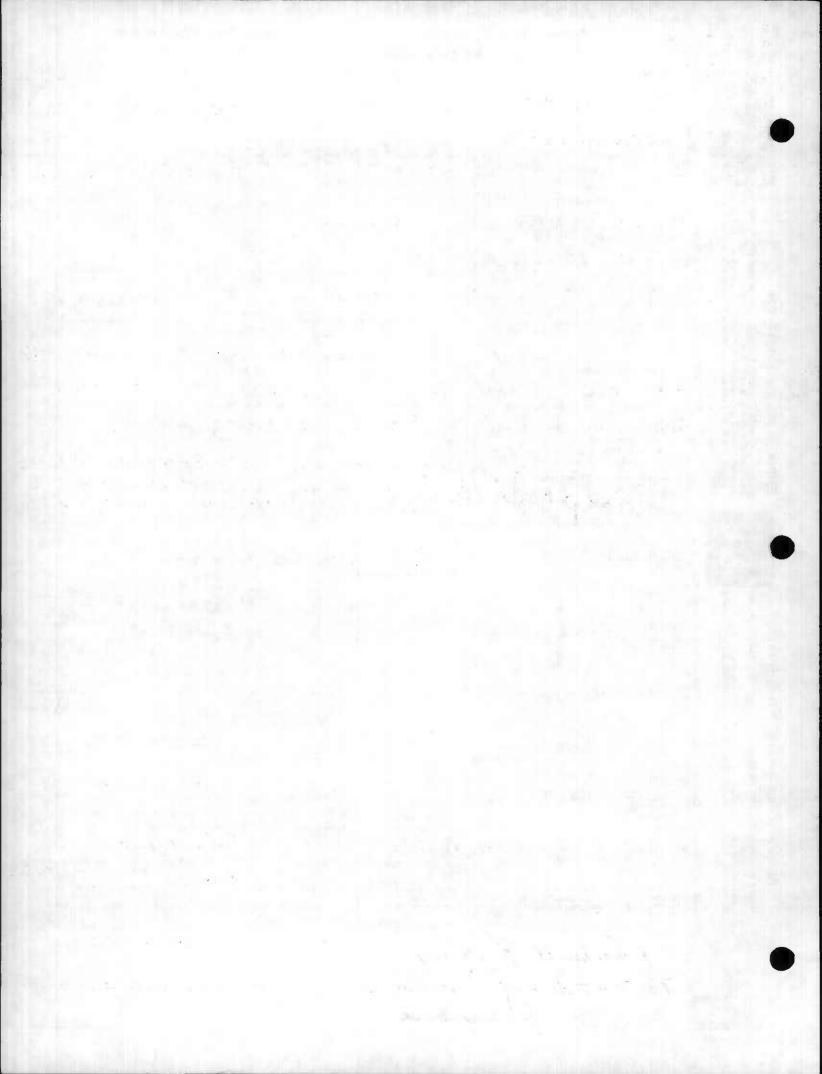
HEDOOKE U.K. Theodore King M.D. 111 Penn Street, Baltimore, Maryland 2 31. Date filed (Month, Day, Year) 12 Fegistrer's Signature

OCME

29c. License number

29d. Date signed (Month, Dey, Year)

JANUARY 21, 1998

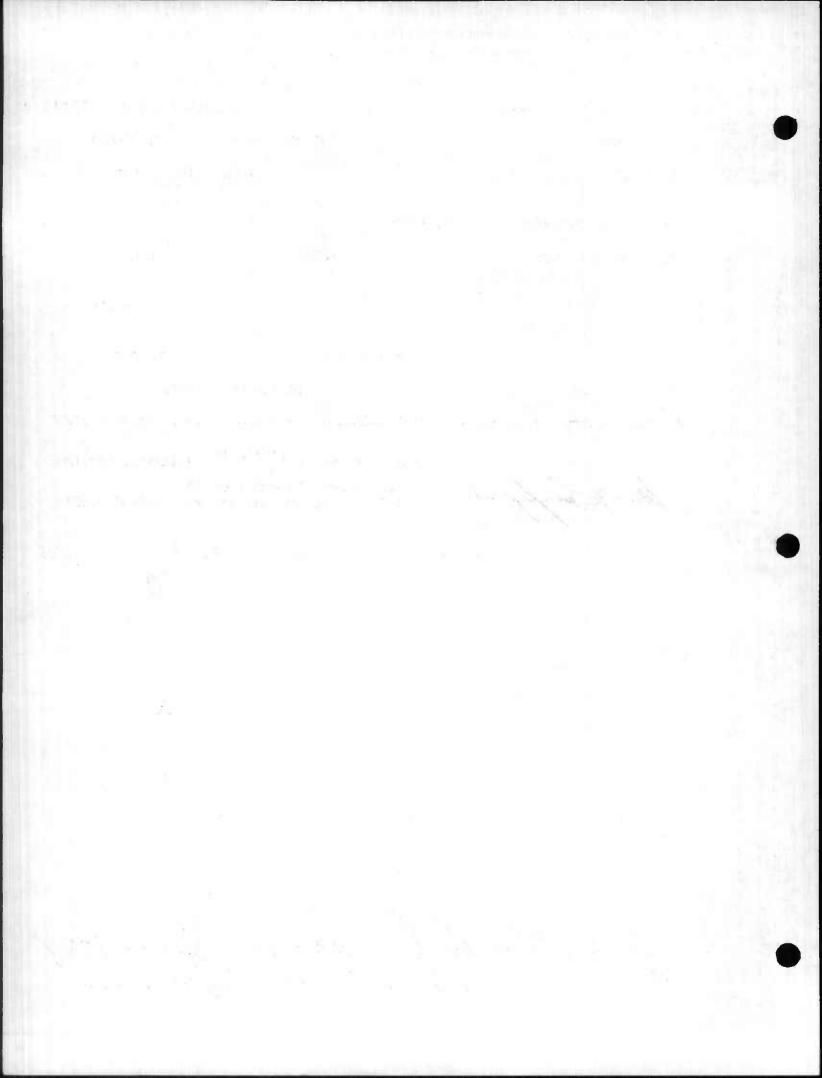


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hale 24, 1998 11:15 am Gwendolyn Marie January /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Middle River Baltimore 2102 Redthorn Road Hours Min. 8. Date of Birth (Month, Dey, Year)

Jan. 9, 1927 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Days 1□ M 2□F New York Yrs Director 71 060 20 5700 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Locetion 10d. Inside City Limits 7 is marked other than "natural", or Itams 23s or 28s-f show traumatic event, the Modical Experient must be notified at 1□ Yes 2□ No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2102 Redthorn Road 21220 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 11 Housewife Own Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Gwendolyn Waite Edwin McCue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health e If Item 27 is or other tra (daughter) 2102 Redthorn Road Middle River, Maryland 21220 Theresa DeLibro 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Depertment of Important: If any injury or 1/27/1998 4 Donation 5 Other (Specify) Greenmount Crematory Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Essex, Maryland 21221 in that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ris cause on each line. Approximete interval Between Onset and Death **Physician** ADENOCARCINOMA of UNKNOWN Etrology /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Attending Physician: The law requires that the death certificete be executed burial-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of) use as ŏ P.O. | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by 3 Probably 4 Unknown 1 Yes 2 No Records, þ eq 24b. Were autopsy findings available prior to page 2 should Completed 24a. Was an autopsy performed? completion of cause of deeth? cartificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To Aftar this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident s after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 24 hours 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

| Description of the description of the description of the description of the cause of the caus 29a. Certifier (Check only one) To the within 2 296. Signature and little of ceptile 29c. License number Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAKLIN 000 MERBACK 1CHOB, 32. Registrar's Signature 31. Date filed (Month, Dey, Yeer) State **JAN 26** Registrar



	Film G-755 1-26-98RC	4 gato of mary		ertificate o		Worker	Reg. No.	0	632	
	1. Decedent's Name (First, Middle, Last Dorothy	P.	Н	enning		2. Dete of D Month Jan •	23, Dey 199	S Seer	3. Time of Deeth 12:45PM	
his certificate has been signed by the ettending physician and significate has been signed by the ettending physician and signification; page 2 should be detached for use as the burial-trensit and increased should be detached for use as the burial-trensit and increased should be detached for use as the burial-trensit. To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director	4a Fecility Neme (If not institution, give	street end number)			4b. City, Town, or Silver	Spring	th 4c. County	of Deeth	ry	
_	5. Social Security Number 6. Se 577-60-4882	7. Age (In 74 74)	yrs. lest birthde Yrs.	Months Day		8. Date of B (Month, D	irth May ay, yeer/1923	9. Birthpi Coun Wash	lace (State or Foreign try) D.C. nington	
fled at	10a. State 10b. County N/A		c. City, Town or Washin	Location).C.			11	0d. Inside City Limits	
Direc	10e. Street end Number 2448 Tunlaw S	treet N W	J	10f. Zip Code	007		10g. Citizen of What Country? United States			
	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:			of Hispenic Origin? (uben, Mexican, Pue	Specify Yes or N rto Rican, etc.)		e - Americ k, White,	an Indien,	
Wedtall	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)		(Gi		ne during most of wi ired)	orking	16b. Kind of Bu	usiness/inc	dustry	
Be	12 17. Father's Name (First, Middle, Last) Carl E. Poore	e, Sr.	Sta	tistica		ame (First, Middl	U.S. (e, Maiden Sumam orand		rnment	
y injury or other traumation	19e. Informent's Name/Reletionship (T) Thomas L. Poore 20e. Method of Disposition 1 □ Burial 2 (Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify) 21. Solution of the all Service License	Brother Removel from State	281 Ob. Plece of Discemetery, of	Calve sposition (Neme of remetory or other) Cremato 22. Neme end Ad	ry	rd. Sil 1-24- 1998 abrose	Catons Funeral	cing City or To 7ill	, MD wn, Stete	
he burial-trensit	Immediate Ceuse (Finel disease or combandor, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b. Crcbv	OU45 CU	sequence of): Sissequence of):	A				Interval Batween Onset end Death 3 weeps 4 weeks	
achec	Pert II. Other algorificant conditions conditions		resulting In the	underlying cause	given in Pert I.		Old tobacco use contribute to the cause of			
2 should b						24e. Wa	s en eutopsy formed?	COI	ere eutopsy findings eileble prior to mpletion of cause deeth?	
Be	25. Was case referred to medical exeminer?	Hospital:			Other	eeth (Check only			Yes 2□ No	
	27. Manner of Death 1 Naturel 5 Pending investigation 3 Suicide 6 Could not be determined	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea 28e. Pleca of Injury - building, etc. (Sp	28b. Time Injury	of 28c. Ir	njury et Vork?	28d. Describe	sidence 6 Other how Injury occurr (Street and Numbown, State)	red		
dical Ce		sician: To the best of my ner: On the besis of exar								
Me	29b. Signature and the of cartiford	s M	>	02	5430		29d. Date signed	48	Day, Year)	
	30. Name and address of person who co	ompleted cause of deeth MO 1433		viel-beu	re Rd t	+307	lavrel, o	10	20708	
State legistrar	JAN 26 1998	Julia Murdon	Mandall							

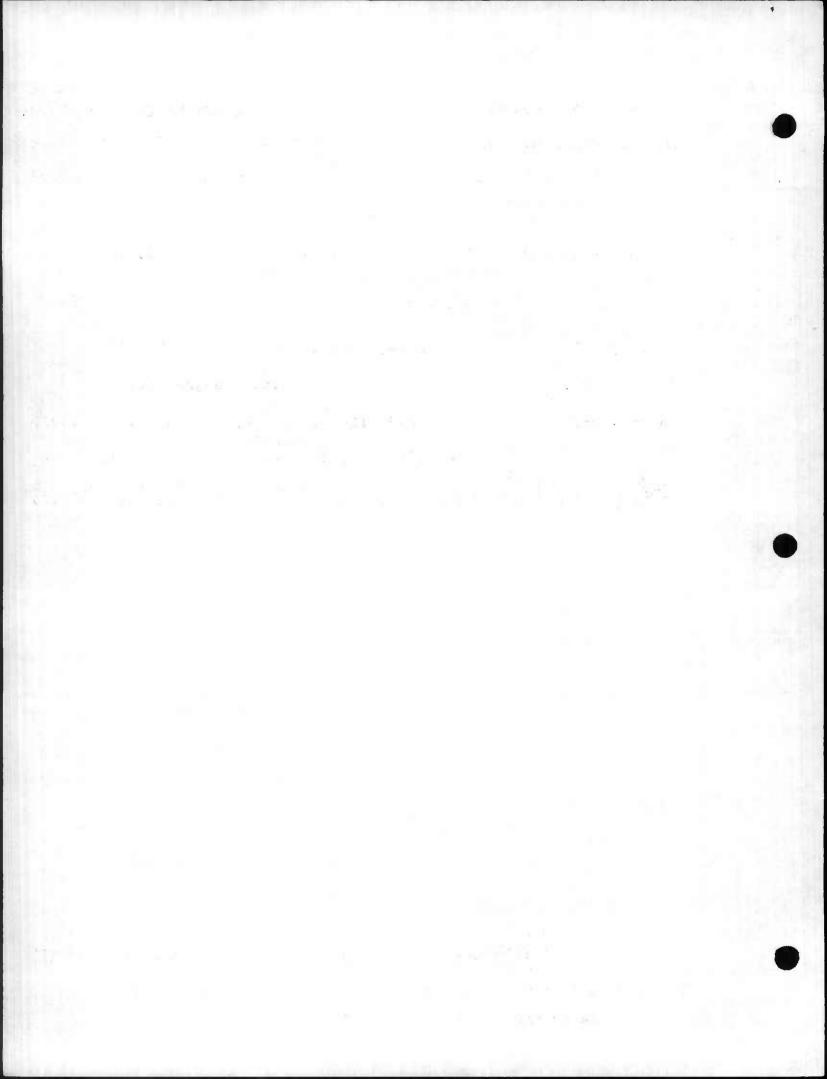
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** JAMES Ε. HUGHES JANUARY 17, 1998 12:30 P.M. /Medical 4a. Fecliity Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner VAMHCS FT. HOWARD DIVISION FORT HOWARD BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
5. Carolina 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours 1√ M 2□ F Months Yrs. 298-36-6462 **Director** 02/26/41 Usuei Residence of Decedent with the Maryland 10b. County 10e. State 10c. City, Town or Location 10d. tnside Clty Limits ir than "natural", or frame 23s or 28s-f show the Wedical Examiner must be notified at MD N/A Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 817 Gilrubin Court, #2 21212 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 7/5/58 If Yes, Give Yeer or Detes: 3/15/62 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 72 hours after 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 200 No **Black** Specify: þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within : nent of Haalth and Mental Hygiene. Int: If Item 27 Is marked other than *1 Elementery/Secondery (0-12) 12th College (1-4or 5+) Chevrolet Plant Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be James Hughes Mattie Hughes-West 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meliing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janet Thomas 817 Gilrubin Court, #2, Balto., MD 21212 other Baltimore. 20b. Piece of Disposition (Name of cametery, cremetory or other piece) 1/23/98 Dete Garrison Forest Vet. Cem. 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any Injury or on 130 Buriai 2 Cremetion 3 Removel from Stete Owings Mills, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name end Address of Fecility LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVE., BALTO. SON FUNERAL HOME, P.A. GHTS AVE., BALTO. 21207 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ist only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical • END STAGE ACQUIRED IMMUNE DEFICIENCY SYNDROME Examiner Due to (or es a consequence of) Examiner attanding physician and for use es the burial-transit that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): ed by the a P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown CHRONIC RENAL INSUFFICIENCY Division of Vital Records, À 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peen BACTEREMIA has cartificata 1 ☐ Yes 2 No 1 ☐ Yes 2 No director. 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred Aftar 1 Neturei 5 Pending I or Attending after death. I Director: Aft 1 ☐ Yes 2 ☐ No investigetion 2 Accident filled in by the 3 Sulcide 6 Could not be determined 28e. Piece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide To the Hospital owithin 24 hours aff To the Funeral DI completely filled is 29a Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dav. Year) empleted cause of deeth (item 23e) (Type, Print) 30. Neme end eddress of person who DR. BALA DUGGIRALA--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

32. Registrere Signeture

Registrar

31. Date filed (Month, Dey, Year)

JAN 26



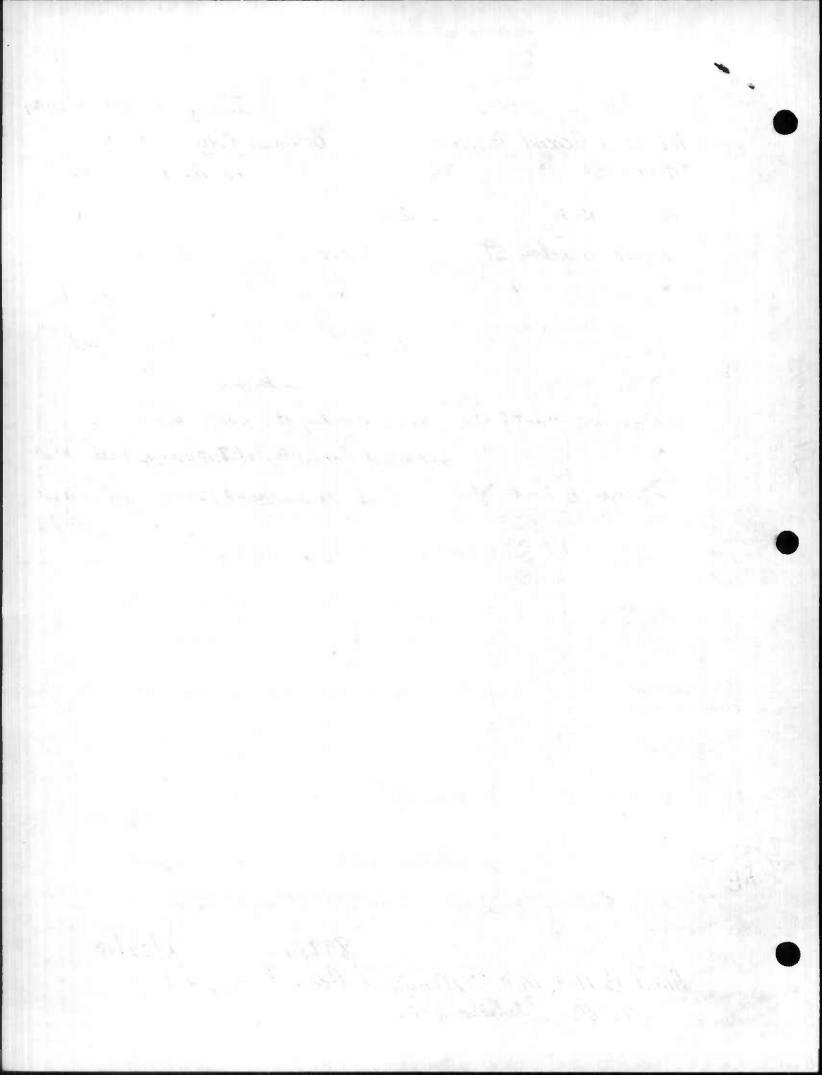
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death **Physician** JOHN C . HENTY Lanuary /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Daatb 4c. County of Death **Examiner** Baltimore
If Under 24 Hrs.
Hours Min. General Bryand HOSpital 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Aga (In yrs. last birthday).

8 6 Yrs. If Undar 1 Yaar Birthplaca (State or Foraign Country) **Funeral** Months Days 217 14 0850 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner itsuit be notified at Balto Director 1. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barclay 21218 items 23a 2440 U.5.A Funeral 12. Was Decadent Evar in U,S. Armed Forces? 1 Myes 2 □ No If Yas, Give Yaar or Dates: 11, Marital Status Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. Pages 1 and 2 should be filed within 72 hours effer of the of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or item 1 Never Married 2 Married 1☐ Yes 2 No Black þ 3 Widowad 4 Divorced Completed 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentery/Sacondary (0-12) Collage (1-4or 5+) untinoun noom 17. Fathar's Name (First, Middla, Last) Be unkn own Henry FRIGNO 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Pnint) CATHERINE HART field 2006 Barclay At Balto. md 21218 important: If item 27 any injury or other to 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal trom State 1/22/18 Girango millo, Md GARRISON Forest Con 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee Finds Home 1304h. Central B. Locks. Lacks Rand. Entar the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one causa on each lina. **Physician** /Medical Immediate Causa (Final disaase or condition rasulting in death) Examiner Physician/Medical Examiner and Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last Due to (or as a consequenca of): Records, P.O. Box 68760 Dua to (or as a consequance of): ete hes been signed by the etter pege 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ Completed 24a. Was an autopsy performed? 24b. Wera autopsy tindings availabla prior to completion of causa ot death? 1 Yes 2 No certificate Division of Vital 25. Was casa reterred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Matural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not ba determined 3 Sulcide 28t. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar (Check only one) within To the F 29b. Signature and title of certitier 29c. License number 29d. Data signed (Month, Day, Year) Ballet, A.D. 22 30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print) Hmg/Ballat, M, D, Yo Maryland

State Registrar

31. Date filed (Month, Day, Year) JAN 26 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death /Month **Physician** 7:40 ERNES E 1998 an /Medical 4b. City Town, or Location of Deeth Baffmvr 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number **Examiner** Bon SEcours Hespita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Mappins | Dave | Hours | Min. (Month, Dey. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 20XF 218-22-6146 74 Yrs. Director South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 No Director MD n/a **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3309 Presstman Street 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiena. nt: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify. by 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Cafeteria Worker USF & G 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Frank Canty Annie Gamble 19e. Intorment's Neme/Reletionship (Type, Print) daughter 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dapartment of Health er Important: if Itam 27 Is any Injury or other tratence. 9318 Park Ave. Bronx, NY Arnette Cunningham 10457 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removal from State 4 Doneyon 5 ☐ Other (Specify) Arbutus Memorial Park Jan 27 Baltimore County, MD 21. Signeture of Funeral Service Licensees 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examine Examiner 50 physician and the burial-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Que to (or as e consequence ot) DAToma Physician/Medical the Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings eveileble prior to completion of ceuse ot deeth? 24a. Wes en eutopsy performed? Completed paga 2 s 1 Yes 2 No 1 Yes 2 No cartificata Be 25. Was case reterred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpetient 3 DOA this 27. Menner ot Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Aftar 5 Pending investigation 1 AtVatural death. filled in by tha f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

the death certificete be axecuted Box 68760. P.O. Records. Division of Vital Hospital or Attending Physician:

Baltimore, Maryland 21215-0020

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24 hours

29a. Certifier

State Registrar

29b. Signature end title of certifier

29c. License number

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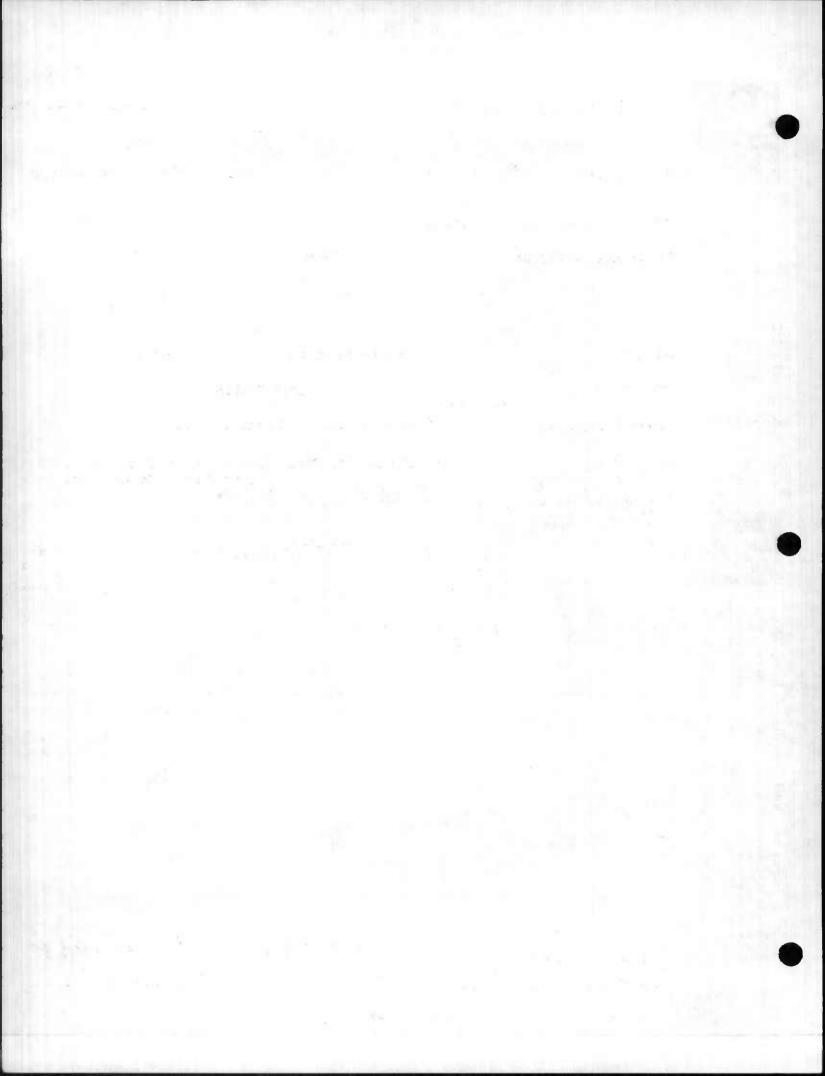
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29d. Date signed (Month, Day, Yeer)

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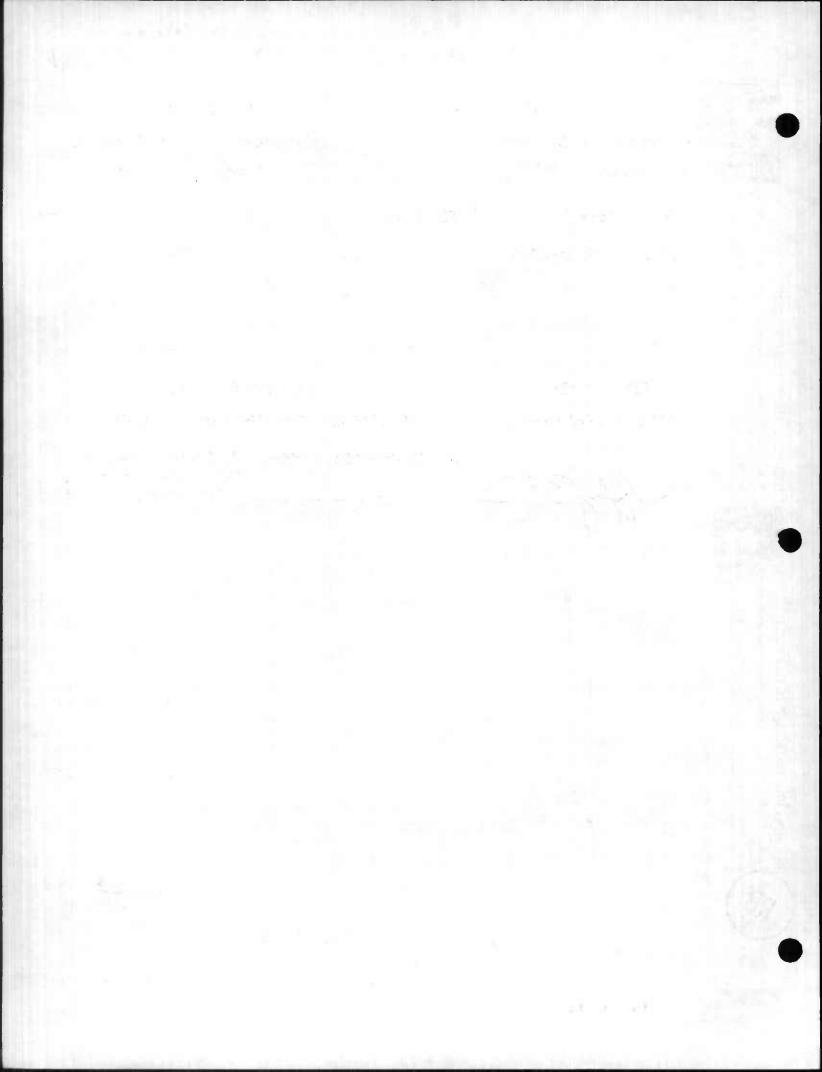


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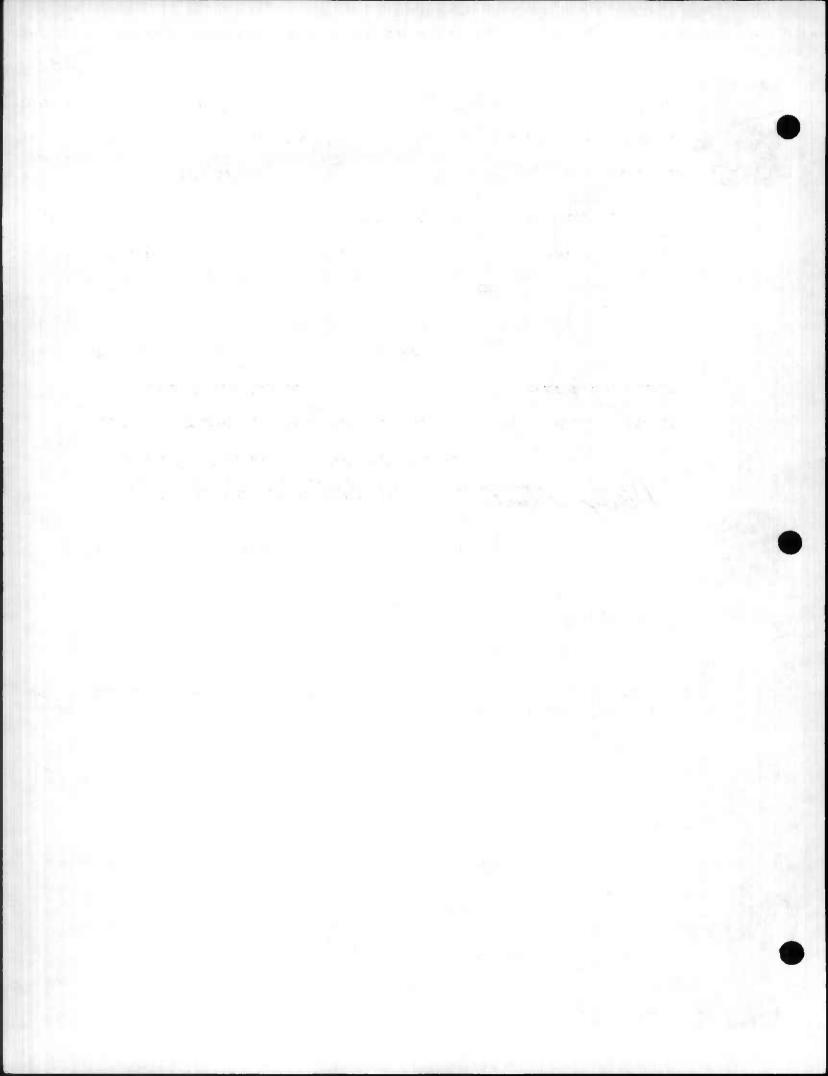
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nysician Medicai	_		PETER	JOHN I	HOOLE			Jan 22	1998	1001	12:05pm			
xaminer	_	4e. Fecility Neme (If not institution,	give street end numb	per)			4b. City, Town	, or Location of Dee	eth 4c. County of De		1			
		Cherrywood Nursi				Who is a 2.2.	Reister			imore				
nerai ector		5. Social Security Number 100-03-0494 Usual Residence of Decedent	6. Sex 7.	Age (In yrs 84	: last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 eys Hours	9. Birthp Coun	lece (State or Forei try)					
11	-	10a. Stete 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Llmi			
notified at	5	MD Carroll		F	inksbur	g								
Direc	3	10e. Street end Number				10f. Zip Co	de		10g. Citizen of	Whet Cour	itry?			
d le	2	223 2 Baltimor	e Blvd			2104	48		USA					
miner n		11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force od 1 Tyes 2 If Yes, Give Year or Date	es? Kano		Vas Decedent f Yes, specify		n? (Specify Yes or N Puerto Ricen, etc.)	lo- 14. Ra Bla Specii	ce - Americack, White,	etc.			
edical Exe	5	15. Decedent's			16e. Deced	ient's Usual O	ccupetion		16b. Kind of E					
r, the Medical S	2	(Specify only highest	grede completed)		(Give	kind of work d OO NOT use re	one during most of	f working	,					
1 0 E	5	Elementery/Secondary (0-12)	College (1-4	Of 5+)	prin	ter			print	ing				
To Be Comp		17. Fether's Neme (First, Middle, L.	ast)				18. Mother's	Neme (First, Middle						
To F	5	William Hool	e				Elizab	eth (unk	nown)					
uma		19a. Informent's Name/Relationshi			19b. Mailir	g Address (St		or Rural Route Numi		, Stete, Zip	Code)			
any injury or other traumones.	1	William Sheedy/	cousin		2232	Baltim	ore Blvd.	, Finksbu	rg. MD 2	1048				
et o	1	20a. Method of Disposition	sition (Name of	of rolece)	Dete	20c. Location		wn, State						
7 0		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe	3 ∐Removal from Sta Becify)	416				nes 1/23/9	98 Hamps	heat	MD			
any injury	1	21. Signature of Fiftheral Service U		Cai			ddress of Fecility		s 1/23/98 Hampstead, MD					
San		D. 18/2	K50					Defe	11824 Reisterstown Rd. Reisterstown, MD 21136					
	+	23a. Part1. Entertheldisesse or c	omplications that cau	sed the dea	th. Do not ent	line Fi	meral Ho			, MD				
ian		23a. Part1. Enter the disease, or c shock, or heart allute. List o	nly one ceuse on eac	h line.			.,	,			Approximete Intervel Between Onset end Death			
dical		tmmediate Ceuse (Final	0 00 4							i	2 ,,11			
iner		disease or condition resulting in deeth) Due to (or es e consedence of):												
ē e	Ö			Due to (or es e conseq	dence of):				1				
the burial-transit		Sequentially list conditions	b	Due to (or es e conseq	uence of):								
		Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury				201100 017.								
icai	2	thet initieted events												
as the	Cause (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of):									į				
			d							1				
9d fo	1	Pert II. Other significent condition	e contributing to deat	h but not res	sulting in the u	nderlying caus	e given In Pert I.	23b. Did	tobacco use co	entribute to	the cause of deat			
datached for us						7	3				pebly 4 Unkno			
d be dat														
should								24a. We	s en eutopsy formed?	24b. We	ere eutopsy findings elteble prior to			
page 2 should	2 -							pen	ioiiied?	COI	mpletion of ceuse deeth?			
Com	5							1□	Yes 20 No	10	Yes 20 No			
Be C		25. Wes cese referred to medical					26. Plece of	Deeth (Check only						
I diractor, pag	0	examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	atient 2	ER/Outpetien	t 3□ DOA	011	ng Home 5 ☐ Res		her (Specifi	()			
		27. Menner of Deeth	28a. Dete of (Month,	Injury	28b. Time of	28c.	Injury et Work?		how injury occu					
the fur	3	1 Netural 5 Pending 2 Accident Investiga		Day rear,	Injury	М	1 Yes 22 No							
Certification:		3 ☐ Suicide 6 ☐ Could no determin	ed 286. Place of	Injury - At h	nome, farm, str	eet, fectory, of	ice	28f. Location	(Street end Num.	ber or Aure	Route Number,			
e e	5		building.	, etc. (opecii	'9)			Only or ve	JWII, Steley					
		29a. Certifier 1 Certifytng	Phyeicien: To the be	st of my kno	owledge, death	occurred et th	e time, date end p	plece, end due to the	e ceuse(s) end m	enner es st	eted.			
	3	(Check only 2 Medical Ex	caminer: On the basi and manner	s of exemina steted.	ation end/or Inv	estigation, in r	ny opinion, deeth	occurred et the time	, date end place,	end due lo	the ceuse(s)			
edical	2		≥ 29b. Signature end title of certifier 29c. License number						29d. Date signe	ed (Month, I	29d. Date signed (Month, Day, Yeer)			
Medical C	- 1	29b. Signature end title of certifier	1	D478					53 1/22/98 SS CTR. DR., Reisterstown !					
edical	- 1	29b. Signature end title of certifier	2 mis			D	4.185	9	1/22	198				
edical	2	Marrie	no completed cause	of deeth (Ite	m 23e) (Tvne	Print)	4'185	9	1/22	198				
edical	2	29b. Signature end title of certifier M. Signature end title of certifier	no completed ceuse of ARRIER			Print) 210 E	3us iness	G CTR.	1/22,	198 elster	stown M			



State of Maryland / Department of Health and Mental Hygiene |

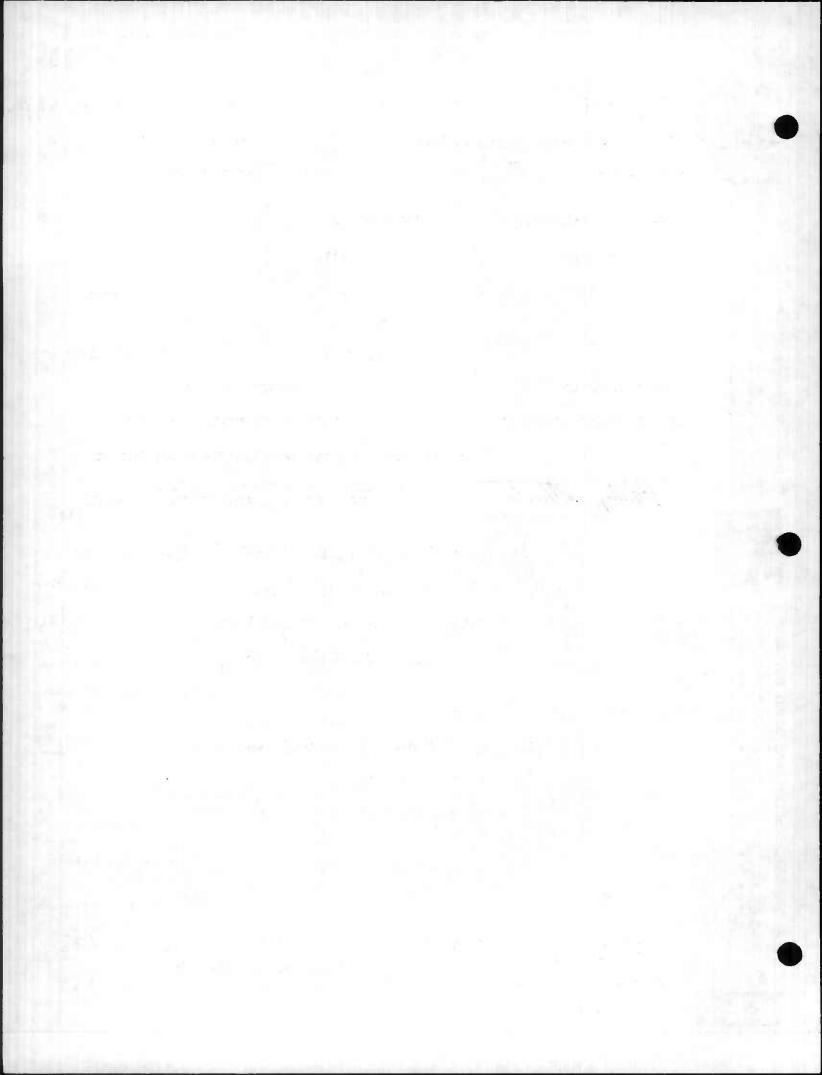
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month a Yr ILLIE 2.10 AM JAN /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** FOREST HAVEN NURSING HOME CATONSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 200 F Yrs. Director 68 572-36-5767 02/21/1929 TX Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Tyes 2 No Director BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 315 INGLESIDE AVE. 21228 U.S.A. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter t Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any Injury or other traumatic event. The Medical 1 ☐ Yes ②€No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 WHITE 1 ☐ Yes 2 ☐XNo Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ARCHIE HOMER McCRIGHT 2 VIRGIE ALBERTA FLOYD 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 44 PEPPERDINE CIRCLE CATONSVILLE, MD 21228 CATHERINE HAYES/DAUGHTER Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) SHAFTER MEMORIAL PARK 1/23/98 SHAFTER, CA 22. Name end Address of Fecility
STERLING ASHTON FUNERAL HOME,
736 EDMONDSON AVE. CATONSVILL 21. Signeture of Funeral Service Licensee EDMONDSON AVE. CATONSVILLE, MD 21228 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Onset end Deeth Physician /Medical PIRATION NEU MONIA-Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician end s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): ettending p ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown UNTINGTONG Records, þ should I 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 1 ☐ Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Plece of Peeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2000 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manyeer of Death Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attending Patter deeth. After Naturel 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 2 4 Homicide Pop. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner steted. 29a. Certifier Medical R 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7220 31. Date filed (Month, Day, Year) State 26 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 201 2:52 01 1am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMUSE N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (Stete or Foreign Country) **Funeral** Months 1 M 20XF Deys 80 Director 217-05-6741 07/12/1917 MD Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD BALTIMORE CATONSVILLE Items 23a or 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funerai 118 FOREST DRIVE 21228 U.S.A. death v 11 Marital Status 12. Wes Decadent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiane. Important: If item 27 is merked other than "natural; or ite any injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married ☐ Yes 2☐XNo Yes, Give Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 VICE PRESIDENT MITCHEL FUR CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ALBERT BUCHWALD 20 LOUISE WEISSNER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CLYDE E. HOSKINS/HUSBAND 118 FOREST DRIVE CATONSVILLE, MD 21228 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 Buriel 2 □ Cremetion 3 □ Removal from State MEADOWRIDGE MEMORIAL PARK 1/24/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funerel Service Licenses 22. Name end Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting In death) /Medical **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Box 68760. ed by the attending physician deteched for use as the burie The law requires that the death certificate be Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, p Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? vacle and Sacril 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To 1 Yes 2 No 1 DInpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 1 W Naturel 28c. fnjury et Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death the 6 Could not be determined 3 Suicide p 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. edical 29a, Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 3100 W. Baltune 30. Neme end eddress at a e of death (Item 23a) (Type, Print) V), ERNARDO Gm2 WM .-18/00 2/223 Baltinn mo 31. Date filed (Month, Dey, Year) State JAN 26 Registrar

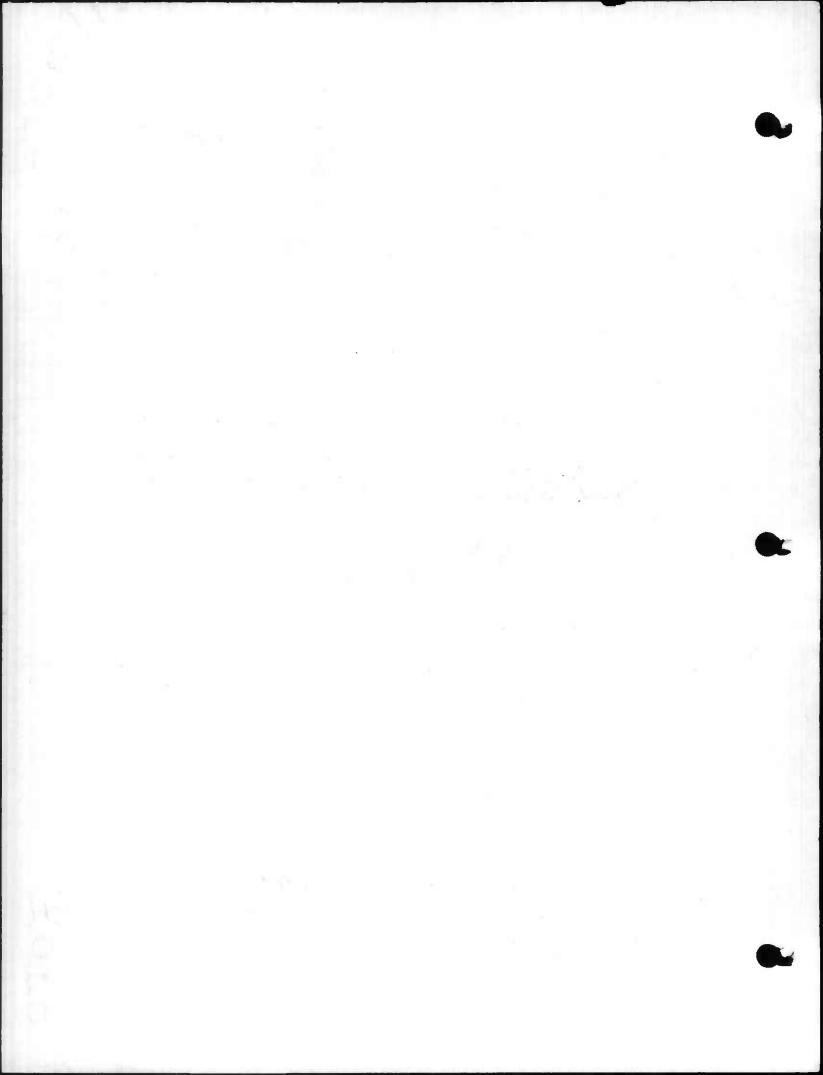


070	Page 6 may be retained by the hospital or attending physician
BALTIMORE, MARYLAND 21215-0020	attending
	6
ND	hospital
3	the
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MAK	retained
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7	may
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Σ	Page
AL	after death. F
מ	after
	-

BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within-14 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	nt, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w	TO THE FOUNTAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the perfited within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGIST STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HEGISTHAN			ERITE	CALE	DEATH	1	REG. NO.					
1. DECEPENT'S NAME (First, Middle, Lest)	1		ERA	ANI		2. DATE OF MONTH	DEATH DA	3	YEAR 1998	TIME OF OEATH 8 19 A N		
4. SOCIAL SECURITY NUMBER 218 96 8771	5. SEX	6. AGE (in yrs. les		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D) Aug.	lay, Year)	905	Country)	ACE (State or Foreign		
Se. FACILITY NAME (If not institution, give s				9b. CITY, TOWN	OR LOCATION OF D							
Genesis Loch Rave RESIDENCE OF DECEDENT 104. STATE 104. STATE 105. COUNTY Maryland Ba	en Health	Center			Towson				Ba1t	imore		
10a. STATE 10b. COUNTY			10c, CITY, TOWN OR LOCATION						10	Od. INSIDE CITY		
	altimore						1	YES 2XXNO				
10e. STREET AND NUMBER 704 Seth Court 11. MARITAL STATUS				1	or. ZIP COOE 21286			0.00		tates		
11. MARITAL STATUS	12. WAS DECEOENT	EVER IN U.S. AR	MED	13, WAS OF	CENDENT OF HISPA		Specify Yea					
3XXWIdowed 4 Divorced	FORCES? 1	YES 2 XINAR OR OATES	10	If yes, a	specify Cuban, Maxica S 2XXNO Specific	an, Puarto Rica	in, atc.)		Black, V Specify:	American Indian, Vhita, atc. Asian		
15. OECEDENT'S EDUC (Specify only highest grade		(G	he kind of w	USUAL OCCUPATION done during n	TION post of working	16b. KII	NO OF BUS	INESS/IND	USTRY			
15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)) 170.	Tomem	retirea.)	iost or working		Owr	n Hon	ne			
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Midd	dle, Maiden	Sumame)				
		Irani			Do	wlat			Ker	mani		
19a. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (Street	and Number or Rural	Route Number,	City or Town	n, State, Zip				
	Godafrid Makujina / Daughter					timore	, MD	212	286			
20a. METHOD OF DISPOSITION 1	oval from Stata	cemetery, cre	matory or oth	F DISPOSITION (I		OATE			City or Town			
21. SIGNAPURE OF FUNERAL BERVICE LIC	et digital	1 Green	1 MOU	22. NAME	atory 1/	24/98 CILITY		Daiti	more,			
* Lister to	Huma	un		8717	Stephen I Green Pa	D. Loh stures	rmann Dr.,	P.A Bal	timor	21286 e, MD		
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that intilated events											
					-							
PART II. Other significent condition	s contributing to	deeth but not re	it not resulting in the underlying ceuse given in F				PERFORMED?			ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE		
					_ '	YES 2	KNO		DEATH?			
DID TOBACCO USE CONTE	RIBUTE TO CAL	JSE OF DEA	TH YES	NON D	UNCERTAI	\Box			'	YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL				N (Check only one			-					
EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER:	me 5 🗆 Rasidenca	8 Other (Sc	necify)					
DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28a. DATE OF I (Month, Da		28b. TIME INJU	OF 28c. IN	JURY AT ORK? YES 2 NO	28d. DESCRI		JURY OCC	CURED			
3 Suicida a Could not be 4 Homicide datarmined	28a. PLACE OF building, a	INJURY — At horate. (Specify)	me, farm, st			28f. LOCATIO City or To	ON (Street ar own, State)	nd Number or Rural Route Number,				
	CIAN: To the best of a											
29b. SIGNATURE AND TITLE OF CERTIFIER	and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	E OF OFATH (ITES	1 27) (5	Defeat)	D-419	01		- /	173	101		
Ziad Min	Zicid Mirta MM, 3007 ENorMem Parkney, Baltimore, MD 21214											
31. DATE FILED (Month, Day, Year) AN 26 1998 AN 26 1998												



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JOHNSON** E. KELSEY 20, :30am JANUARY 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner stley Hvenue If Under 24 Hrs. 8. Date of Birth Mours Min. Month, Dey, Year) Anne Hrunde 7. Age (In yrs. lest birthday) Social Security Number **Funeral** Min. M 2DF Months Deys Hours Yrs.) une 22 1947 M Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo Hone 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HVenue 21146 Funeral r deeth Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No IYes, Give 0-30-67 Yeer or Detes: 01-30-70 Raca - American Indian, Black, White, etc. 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Peges 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene. ant: If item 27 is marked other than "natural; or its ury or other traumatic event, fire Medical Examinary or other traumatic event, fire Medical Examina. 1 Never Married 2 Married Specify: Black 1□ Yes 2 No altimore, Maryland 21215-0020 Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) hnician Kaylroad 2 yes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be TOT owse Blount ohnson 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Severna Park, Mary and 21146 Dete 20c. Location - City or Town, State (Sister) 104 Westley Avenue vanessa 20e. Method of Disposition permit. Peges Department of Important: If it any Injury or o Burial 2 Cremation 3 Removal from State emeteril-26-98 Crownsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 230SEPHAH. BROWN UR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 narron 23a. Part1. Enter the disease, or complications that cause he death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 8 marth morendic Carre Examiner Due to (or as a consequence of). Physician/Medical Examiner end -transit The law requiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician e Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? nis certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) P 1□ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Yes 2 No 2 ☐ Accident efter death. Director: A 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours efter the Funeral Direction in plately filled in b Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the I within 2. To the F complet 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 29b. Signature and title of cartifie

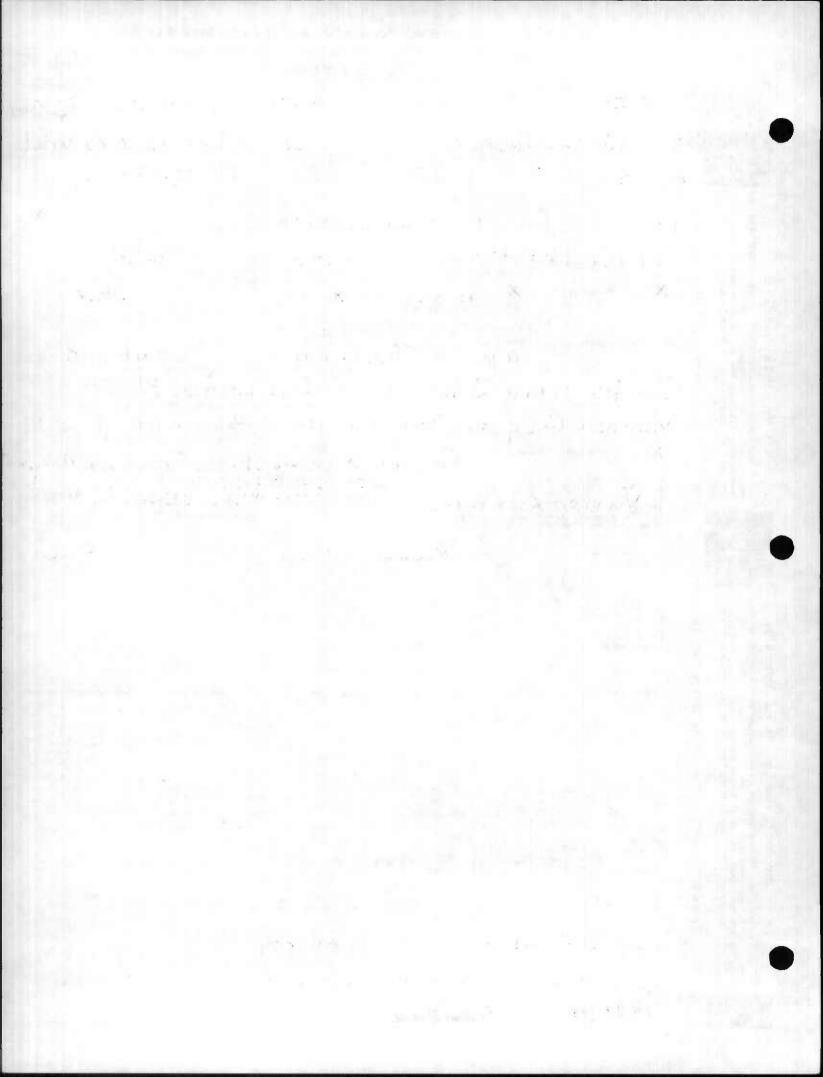
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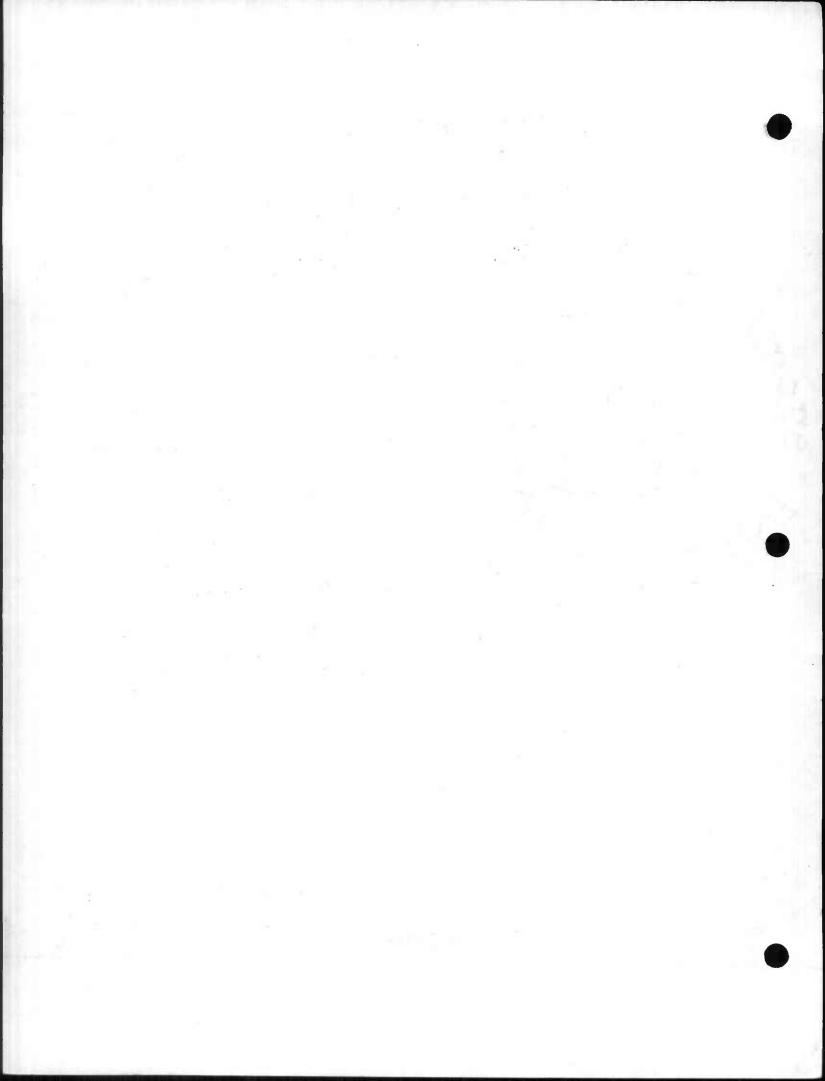
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OTHER HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	OTHE FONERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be de	A D
E	F	file
0	0	03

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT		MENTAL HYGIEN	E						
	1. DECEDENT'S NAME (First, Middle, Last) THELMA KATH	ERINE JO	NES		2. DATE OF DEATH DA		3. TIME OF DEATH 03:30 AM					
	217-10-1157	SEX 6, AGE (In yrs. I	YRS. MONTHS	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year)	15 We:	RTNPLACE (State or Foreign suntry) st Virginia					
OR	9e. FACILITY NAME (If not institution, give stree Manor Care — Rossvi			OSSVILLE	EATN	Baltin						
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Baltimo	ore	10c. CITY, TOWN OR			10d. INSIDE CITY LIMITS? 1 YES 2X						
	100. STREET AND NUMBER 1109 't'C't' Old Easter			101. ZIP CODE 21221		10g. CITIZEN O	DF WHAT COUNTRY?					
BY FUNERAL		2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 I IF YES, GIVE WAR OR DATES	NO II	AS DECENDENT OF NISPA yes, specify Cuben, Mexic YES 2 NO Speci	en, Puerlo Rican, etc.)		MACE — American Indian, Hack, White, etc.					
PLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co	mpleted) College (1-4 or 5 +)	DECEDENT'S USUAL OCC (Give kind of work done du tie. Do NOT use retired.) HOUSEWIFE	CUPATION ring most of working	16b, KIND OF BUS	Own Hon						
COMPL	17. FATHER'S NAME (First, Middle, Last)		HOUSEWITE	18. MOTHER'S N	AME (First, Middle, Maiden							
E U	Russell Ba	arb		Haze	el Bogg	s						
B	19e. INFORMANT'S NAME (Type/Print)	n, State, Zip Code)									
2	Orilas Jones	ex, Mar	ryland 21221									
E ISIN	20c. METHOD OF DISPOSITION 1 Burlisi 2 Cremetion 3 Removal from State 4 Donestion 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Completery, crematory or other place) Cremetory 1/24/98 Baltimore, Maryl											
ехашше	21. SKIND TURE OF FUNERAL SERVICE LICEN	ISEE		ame and address of F uzdzinski F 07 Old East			Maryland 2122					
CERTIFICATION TO BE COM	23. PART II Enter the diseases, or conshock, or heart failure. List iMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentisity list conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	ch ss cerdlec or reepl	ratory arrest,	Approximate Interval Between Onset and Death 3 days								
AN: MEDICAL CE	PART II. Other significant conditions IDDM Hilar Wan DID TOBACCO USE CONTRI	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO										
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL HOSPITAL:	ACE OF DEATH (Check o									
YSIC!	1 TYES 2 NO	□ Inpatient 2 □ ER/Outpatient	3 DOA 4 Nurs	ng Home 5 - Reeldence	-							
ZE IS marked, or TED BY PHY	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURE	D					
	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — At building, atc. (Specify)	home, tarm, street, tecto	ry, offica	28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLE	anal and	AN: To the best of my knowledge, On the basis of examination end/o					use(s) end menner es atated.					
TO BE COMPLE	296. SIGNATUREAND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 1 - 17 - 98											
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	JAN 26 1998	32 AEGISTRU'S SIGNATURE	andelle.									



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	Examine	r	4a Facility Name		100000000000000000000000000000000000000	number)						ation of Death				
	Funeral Director		5. Social Security 212-60-		6. Sex 1€EM 2□ F	7. Age (In yrs	s. last birth Yı	Mont	nder 1 Yeer ths Deys		IMORE 24 Hrs. Min.	8. Date of Birth (Month, Day MAR 2	h	Count	ace (State of	
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2 Pot				15. Decedent's			16a. C	ecedent's l	Usual Occu	pation		16b. Kind of Business/Industry				
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end 2	5 1 3		CRYSTA					1541								
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	Department Important: I any Injury o office.	+	21. Signature of			- 02	11(1(1)						VERAL H		LLS, M	עו
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Phy	ysician	1	23a. Part1. Enter shock, or he	the disease, or coart failure. List o	complications that nly one ceuse or	t ceused the dea	ath. Do no	t enter the	mode of dy	ing, such as	cerdiac or	respiratory ar	rest,		Approxima Interval Bei Onset end	tween
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	page page	5										X	es 2□No	1/2	Yes 2□] No
Ita		D	25. Was case referred to medical 26. Disco of							of Death	(Check only or	ne)		,		
of Vital	l direct	0	Hospital:						ne 5 Resid	5 ☐ Residence 6 ☐ Other (Specify)						
D D	era .		28a. Date of Injury 28b. Time of 28c. Injury at 28							8d. Describe h	now injury occur	red				
Sion	tor: After the fun-		200 Accident	investiga	ition 1/21		unkn	M		Yes 2 (X)	No SI	ubject_d	rowned			
40 40 4	3 - 3	~	3 ☐ Suicide	6 Could no	DI DO	411 41					0	Of Leaguine /C	Street and Alicet	anna - Dunal	Davida Alica	. 6

Division of Vital Records, P.O. Box 68760, To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the Medical Certif

4 Homicide

Place of injury - At hon building, etc. (Specify)

City or Town, Stete 2517 Salerno Place,

home

Baltimore, Md.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Sign

O.C.M.E

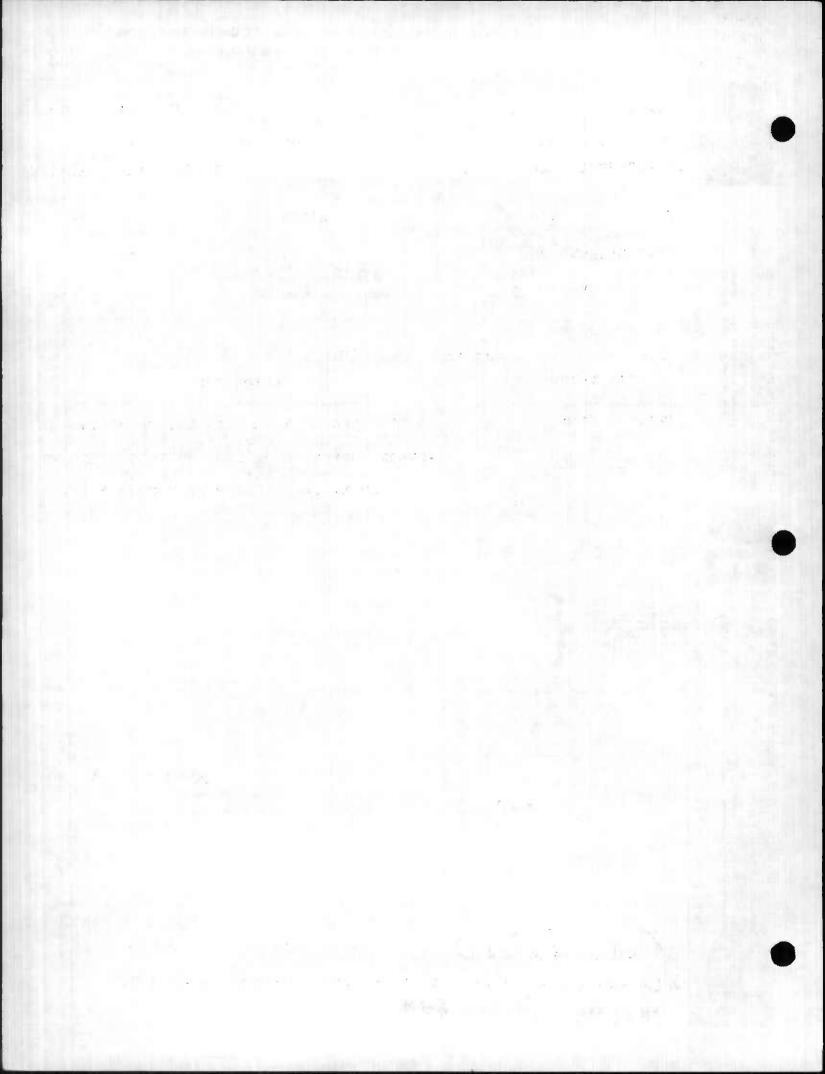
JAN. 22, 1998

of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 29a. Certifier (Check only only)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Virgil 16, 1998 9:23 P. M. Ira Keller January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Wonths Deys Hours Min. July 3, 19 4909 E. Chase Street N/A 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number **Funeral** 1 M 2 □ F 1918 236-12-6717 **Director** Usual Residence of Decedent filed withIn 72 hours aftar death with the Marvland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Mexical Examiner must be notified at 1 Yes 2 □ No Baltimore Directo Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U. S. A. 4909 E. Chase Street Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 🕅 No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify. p 3 Widowed 4 Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pagas 1 and 2 should be family of Health and Mental Int: If Item 27 is marked of Ira Keller Rosie Selvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4909 E. Chase Street, Baltimore, Maryland 21205 Bertha Keller (Wife) or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or pace. Holly Hill Mem. Gardens 1/20/98 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician a of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 8 ose Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 6 1 Pres 2 No 3 Probably 4 Unknown signed to the by 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24a. Wes en eutopsy performed? Completed certificate ha 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Applident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ass of person who completed cause of death (Item 23a) (Type, Print)

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State

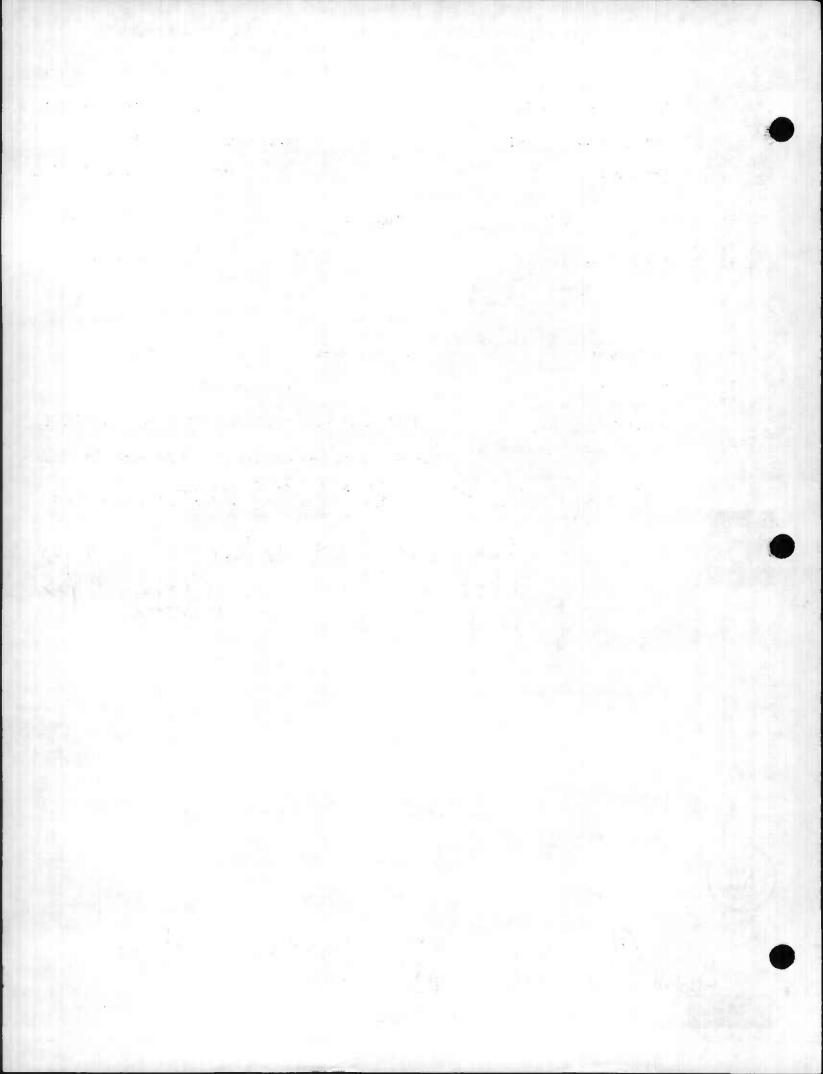
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31. Date filed (Month, Day, Year)

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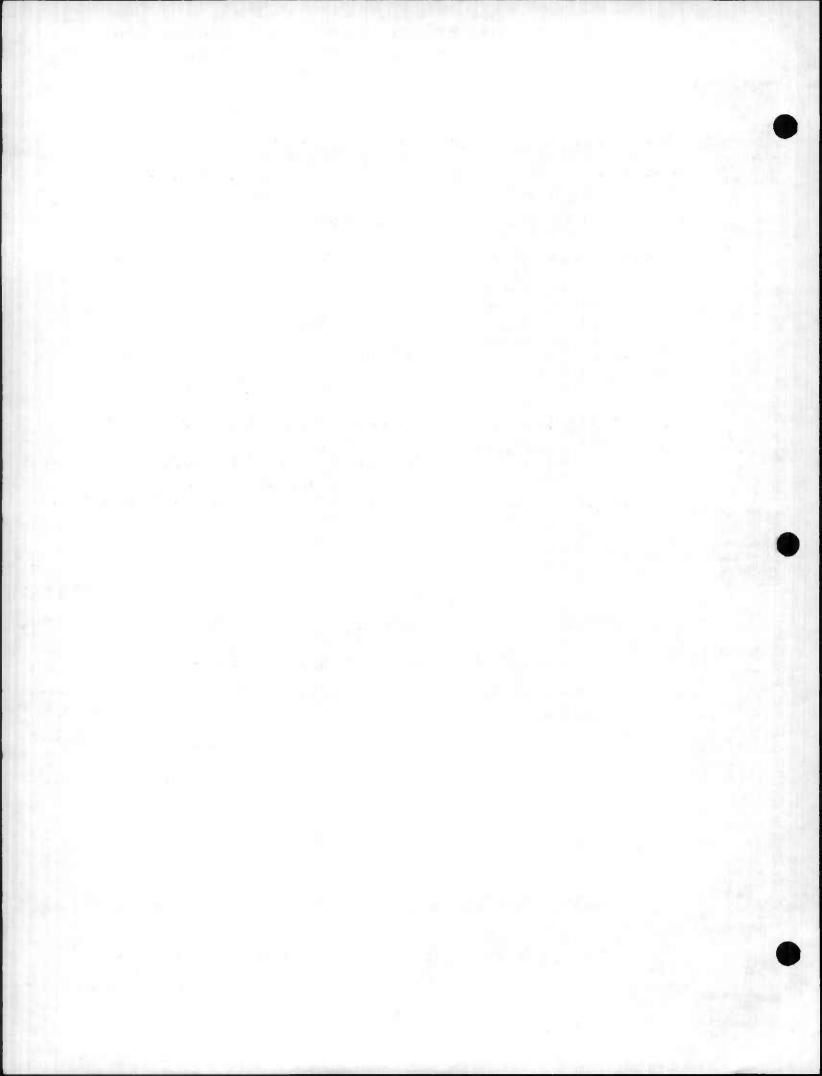
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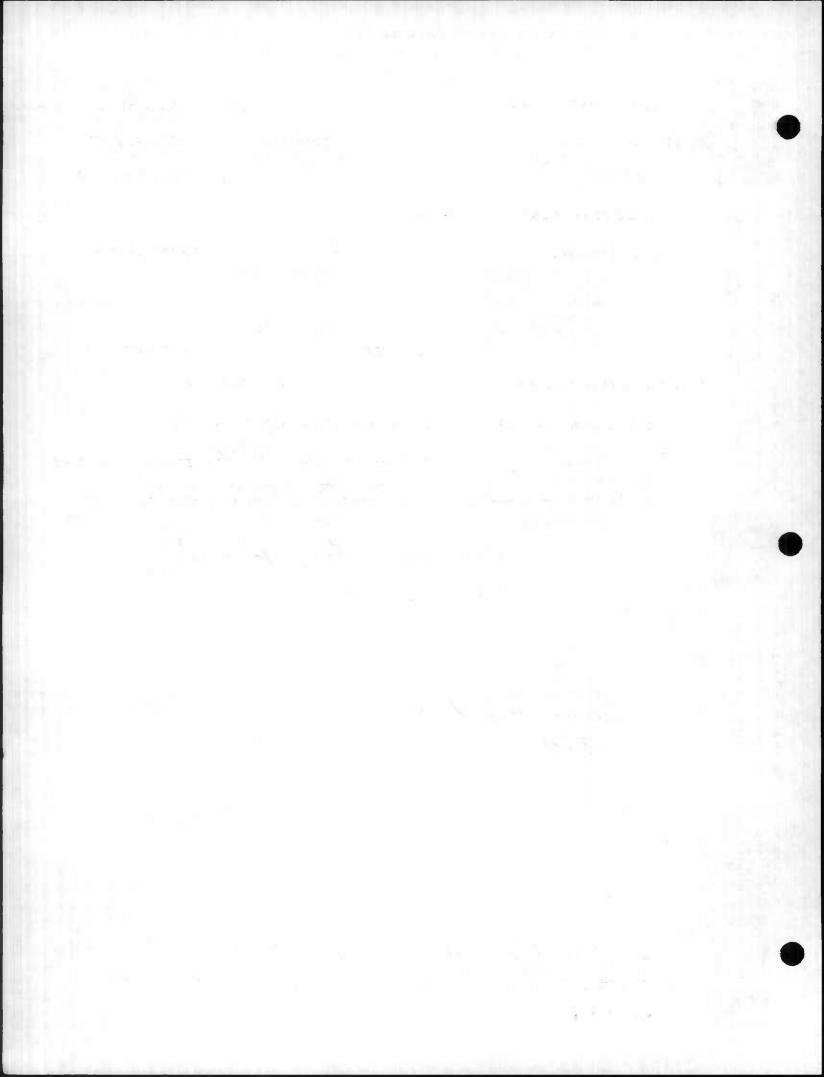
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M 2□ F 43		Months Days	Hours Min.	(Month, Dey Oct. 10	Year)		ace (State or I (ry) (Land
10c. C	ity, Town or Locati	ion				10	d. Inside City
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	1	10f. Zip Code			log. Citizen of V	Vhat Count	ry?
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2. Was Decedent Ever in the Armed Forces? 1 Yes 2 No lif Yes, Give Year or Dates:	If Ye	S Decedant of Hes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	etc.
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ospital:		Oth	oer:	ath (Check only or			
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28a. Dete of Injury (Month, Dey Year)	Injury	28c. Injui Wor	rk? Yes 2 □ No	200. Describe II	ow injury occurs	60	
28e. Place of Injury - At h	nome, farm, street,			28f. Location (S	treet end Numb	er or Rural	Route Numbe
building, etc. (Speci	ify)			City or Tow	n, Stete)		
clan: To the best of my kno	owledge, death occ	curred at the tir	me, date end plece	, and due to the c	euse(s) end ma	nner as ste	eted.
er: On the basis of examina and manner stated.	ation and/or Investi	igation, In my o	ppinlon, death occu	rred et the time, d	ate and place,	end due to	the cause(s)
NA		29c. Licans			9d. Date signed		
MEDICAL	RESIDENT	T RE	5-000) (aning	123	1998
npleted cause of death (Ite	m 23a) (Type, Prin	it)		A	- i-wi	It	1. 100
100 N.W	ble she	90t, 17	MI VISING	, baltin	none in	lung	and 217
)	600 N. W	pleted cause of death (Item 23a) (Type, Prin OO N WOLC S M 32, Registrar's Signature	pleted cause of death (Item 23a) (Type, Print) (00 N WOLES HOLL) 32, Registrar's Signature	pleted cause of death (Item 23a) (Type, Print) (OO N. WOLEC STOCK TOWNER INC. 32, Registrar's Signature	pleted cause of death (Item 23a) (Type, Print) (OO N. WOLCE STREET, TOWER 110, bolling 32, Registrar's Signature	pleted cause of death (Item 23a) (Type, Print) (OO N. WOLFE STREET, TOWER 110, BOUNMONE, IN 32, Registrar's Signature	600 N. Wolfestreet, Tower 110, baltimore, Mary



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Last)		001	tificate	, 01	Douth	2. Dete of Dec	Reg. No.		3. Time of Leeth
Physicia		ROLAND L. KOONTZ,							JANUAR	Day	998	9:00 A.M
/Medic Examin		4a. Fecility Name (If not institution, give	street and number,)	- WA			4b. City, Town, or L	ocation of Deeth	4c. Count	y of Death	
		213 S. DRUM AVE.		N.				PASADENA			ARUND	EL
Funeral Director		5. Social Security Number 6. Se 212-05-2273	Z _	ge (In yrs. la 85	ast birthday) Yrs.	If Under 1 Months	Deys	Hours Min.	8. Dete of Birt (Month, De JAN. 2,		9. Birthpl Count PENNS	eca (Stete or Foreign try) SYLVANIA
the Maryland 28a-f show	tor	10e. Stete 10b. County MARYLAND ANNE ARU	NDEL		, Town or Lo	cation					16	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
th with 23a or	Funeral Director	10e. Street end Number 213 S. DRUM AVE.				10f. Zip (Code 122			10g. Citizen of UNITED		•
aftar or ite	þ	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates:					dispenic Orlgin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bio Speci	ca - America eck, White, of	an Indien, etc. ITE
within 72 ene. than "nat	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or	5+)	16e. Deced (Give life. L MACHI	kind of work OO NOT use	Occup done retire	petion during most of work d)	ing	16b. Kind of I		
be filed trail Hyg d othe event,	To Be Co	17. Fether's Name (First, Middle, Last) WILLIAM OLIVER KO	ONTZ					18. Mother's Nem CLARA B	e (First, Middle, ELLE BU		me)	
2 shou end M Is mer aumet		19a. Informent's Neme/Relationship (Ty	rpe, Print)		19b. Mailin	g Address	(Street	end Number or Rur	al Route Numbe	r, City or Town	n, Stete, Zip	Code)
		ELAINE F. KOONTZ	/ WIFE					VE., PASA	DENA, M	ARYLANI	2112	2
age ent o tr: If		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Øther (Specify)		Ca	ece of Disponentery, crent ADOWRII	netory or oth	her ple	DI	Dete ANUARY 8, 1998	20c. Location ELKRID		
pemit. Pa Departmer Important: any Injury		21. Signature of Euneral Service Lidens	لت		KI	RKLEY	-RU	ess of Fecility DDICK FUN HWY., S.E				1061
tificete be ig physicia es the bur	Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	And	Due to (or	es e conseque	uence of):	7	7. 0				
that the deeth certif ed by the ettending deteched for usa er	Physician/M	Part II. Other eignificent conditions con		nit not resu	lting In the ur	nderlying ca	use ni	ven in Pert I	23b Did t	obacco usa c	ontribute to	the cause of death?
requires that the deeth cer een signed by the ettendin hould be deteched for usa	by Phys	alytes	itributing to death b	de.	un	٦,	200 g.,			res 2⊟No		ably 4 Unknown
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Physician: The ribis certificate ral director, pag	o Be	25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No	lospitel:		-D/O		Oth	26. Place of Deat				
To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate ha complataly filled in by the funeral director, page	ation: To	27. Manner of Deeth 1 XNaturel 5 Pending 2 Accident investigation	28e. Dete of Inju		ER/Outpatien 28b. Time of Injury		c. Injur	4 🗆 IAMISING LIC	me 5 🖾 Resid 28d. Describe h			0
tal or Atterns effer de la Directo	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of In building, ef	ury - At hor c. (Specify)	me, ferm, stre	et, factory,	office		28f. Location (S City or Tow		ber or Rura	l Route Number,
n 24 hou	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	eiclan: To the best ner: On the basis o end menner st	f exemineti	vledge, deeth ion end/or inv	occurred el estigetion, i	t the tir in my o	me, dete end plece, ppinion, deeth occur	end due to the ored et the time,	ceuse(s) end n dete end placa	nenner es st , and due to	eted. the cause(s)
表 生 表	Σ	29b. Signeture end title of cartiller	4			29c.	Licens	se number		29d. Date sign	ed (Month, I	Dev. Year)
PH.		30. Name and eddress of person who co	before				D	1620	8	JANUAR	Y 26,	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month Yaar 1970070 1998 JANUARY 14, 10:35PM 4a. Facility Nama (if not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore City THE JOHNS HOPKINS HOSPITAL BALTIMORE
If Undar 1 Year If Undar 24 Hrs. CITY 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 1□ M 25 F Months Days Hours 223-34-1581 68 Yrs. 3, 1929 Virginia Aug. Usual Residanca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1729 East Lombard Street 21231 U.S.A. 12. Was Dacedant Evar in U.S.
Armed Forcas? unknown
1 | Yes 2 | No
If Yas, Giva
Yaar or Datas: 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White 3 XWidowad 4 □ Divorcad 15. Decedent's Education (Spacify only highast greda complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Thomas Ballace Addie Lovilt 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Elizabeth Allen/sister unknown 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 ➡ Othar (Specify) in state 21. Signature of Paneral Service Licensee 22. Nama and Addrass of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 arder art1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximata Intarval Betw Onsat and Death Immediate Ceusa (Final disaasa or condition resulting in daath) month Dua to (or as a consequence of): Due to (or es a consaguança of): Dua to (or as a consaquance of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 N No 1 ☐ Yas 2 ☐ No 26. Plece of Deeth (Check only ona)

Physician /Medical Examiner

physicien end s the burlel-transit

98 ettending I esn

ed by the e

signed by

peeu page 2 has

certificate

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, it

To the Hospital within 24 hours a To the Funeral Completely filled

The law requires that the death certificeta be executed

P.O. Box 68760

Division of Vital Records,

Physician

/Medical

Examiner

10a Stata

Director

Funeral

b

Completed

Be

2

Funeral

Director

7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumate.

Baltimore, Maryland 21215-0020

deeth with the Meryland

Examiner Sequentially list conditions, if any, laading to Immadiata causa. Entar UndarlyIng Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last Physician/Medical þ

Completed 8 Certification: To

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa refarred to medical axaminar? Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 1 Yas 2 No 2 ER/Outpatiant 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Panding invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be Location (Straat and Number or Rural Routa Number, City or Town, Stata) Pleca of Injury - At homa, farm, straet, factory, offica building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifian

23e) (Type, Print)

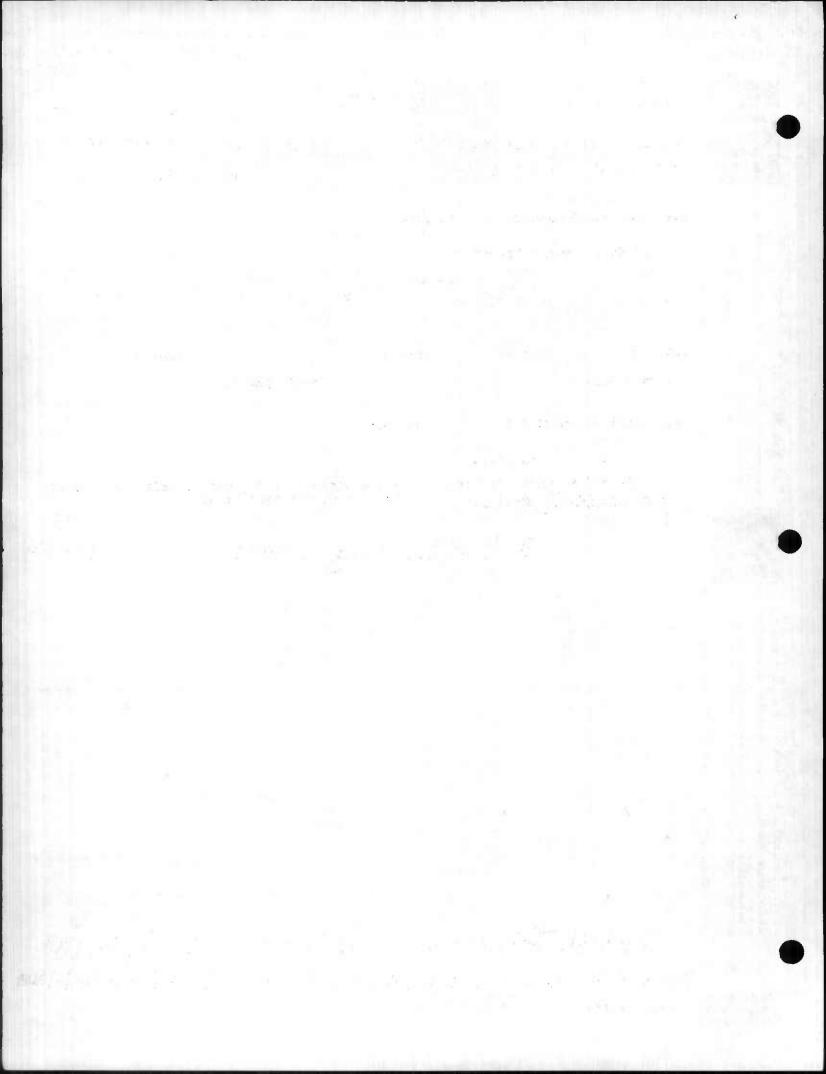
29c. Licansa numbar

29d. Date signad (Month, Day, Year)

State Registrar

31. Data filed (Month, Dey, Year) JAN 26

ins thespital, 600 W. Wolfe St., Baltimore, Maryland 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth 3. Time of Deeth Month Wanda Lee Lowe 0735 Jan. 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Deeth Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 □ M 2 1 F 232-32-5225 Yrs 70 Virginia Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Hagerstown 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 241 South Prospect Street USA 21740 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Richard Rudolph Smallwood Jane Elizabeth Bell 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) Hebie Armstrong - niece Route 2, Box 99J, Charles Town, WV 25414 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery 1/15/98 Berryville, VA 22. Name end Address of Fecility Enders & Shirley Funeral Home, P.O. Box 106 Berryville, VA 22611 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24e. Wes en autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - Af home, farm, sfreet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide

Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner es steted.

| Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner estated.

| Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner estated.

29c. License number

Examiner Division of Vital Records, P.O. Box 68760.

ettending physician end for use es the buriel-transit signed by the e efter death. Director: After this certificate has been To the Hospital within 24 hours a To the Funeral Completely filled

Physician

/Medicai

Examiner

Director

Funeral

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Completed

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Physician/Medical

Completed

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Certification:

29a. Certifier (Check only one)

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

filed within 7 Hygiene.

pernit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event

Physician /Medicai

Baltimore, Maryland 21215-0020

State Registrar

30. Neme end address of 1ed 31. Dete filed (Month, Day, Year)

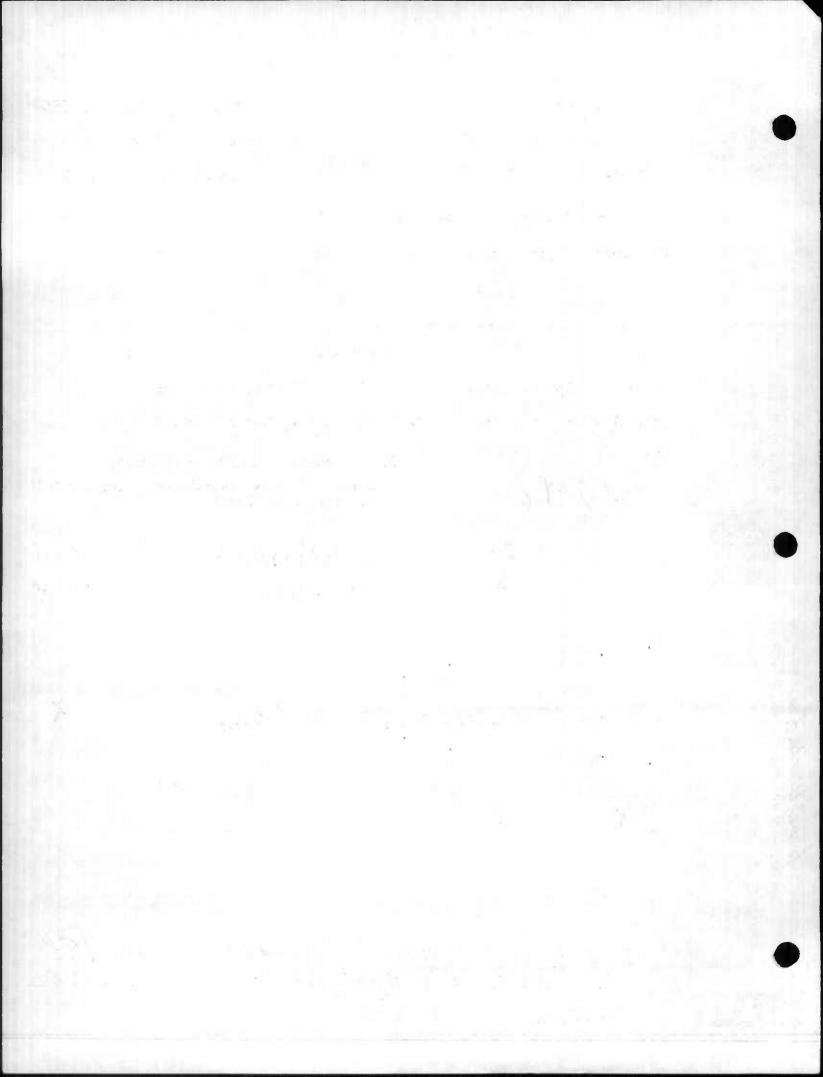
JAN 26

29b. Signeture end title of certifier

32. Registrer's Signature whia Davidson SERFTUN 191)

29d. Date signed (Month, Day, Fear)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middia, Last) 2. Date of Death Month Mildred Lackey January 1998 4e. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Regional Hospital Prince George's Laurel Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Deys 1□M 2XF 187-09-3162 Mar. 15, 1915 PA Usual Rasidanca of Dacedani 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Howard Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6336 Cedar Lane #337 21044 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Navar Married 2 Married 1 Yas 2 XNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry U.S. Soldiers and Elamantary/Secondary (0-12) Collaga (1-4or 5+) Airmans Home Librarian 12 N/A 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Ben F. Seidel Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, Cify or Town, Stata, Zip Coda) J. Lee Lackey (Son) 5971 Grand Banks Road, Columbia, MD 21044 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) JarPata 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Removel from Stata Baltimore/Washington Crem. 22,1998 Laurel, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funaral Service Licenses 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Immediata Causa (Final Ischemic cardio myopathy disaasa or condition rasulting in death) 1Schemic Sequentially list conditions, if eny, laading to immediata cause. Enter Undarlying Causa (Disease or Injury that initiated events rasulting in daath) Last capalio vasantar diseas 4 Therosclerotic Dua to (or as a consequanca of 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus 24b. Wara autopsy findings evailable prior to completion of causa of death? 24e. Wes an autopsy performed? brain syndrome 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona)

Examiner physician end s the buriel-transit certificete be execu Division of Vital Records, P.O. Box 68760, Physician/Medical ettending Por been signed by the e should be deteched f þ Completed Be 2 on: After or Attending Director: Aff To the Hospital
within 24 hours a
To the Funeral
completely tiled

Physician

/Medical

Examiner

Funeral

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r than "netural", or itsms 23a or 28a-f show the Maxical Examiner must be notified at

the Maryland

death

filed within 72 hours efter

permit. Pages 1 end 2 should be filed within 7. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, in Mean once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was casa refarred to medical

1 ☐ Yas 2 ☑ No	Hospital: 118 Inpatient 2	☐ ER/Outpatient 3	□ DOA	Othar: 4	☐ Nursing Ho	ome 5 Rasidance 6 Othar (Specify)
Z L Accidant	ding (Month, Day Year)	28b. Tima of		Injury at Work?		28d. Describe how Injury occurred
3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicida deta	d not be rminad 28a. Place of Injury - At building, atc. (Spe	homa, farm, streat, f	actory, off	ice		28f. Location (Streat and Numbar or Rural Routa Number, City or Town, Stata)
20a Cartifiar 15 Cartif	doe Physician. To the heat of my le	noudedee deeth con	consel as the	- 4:		

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceusa(s)

29b. Signetura end titla of certifian 29c. Licanse number 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)

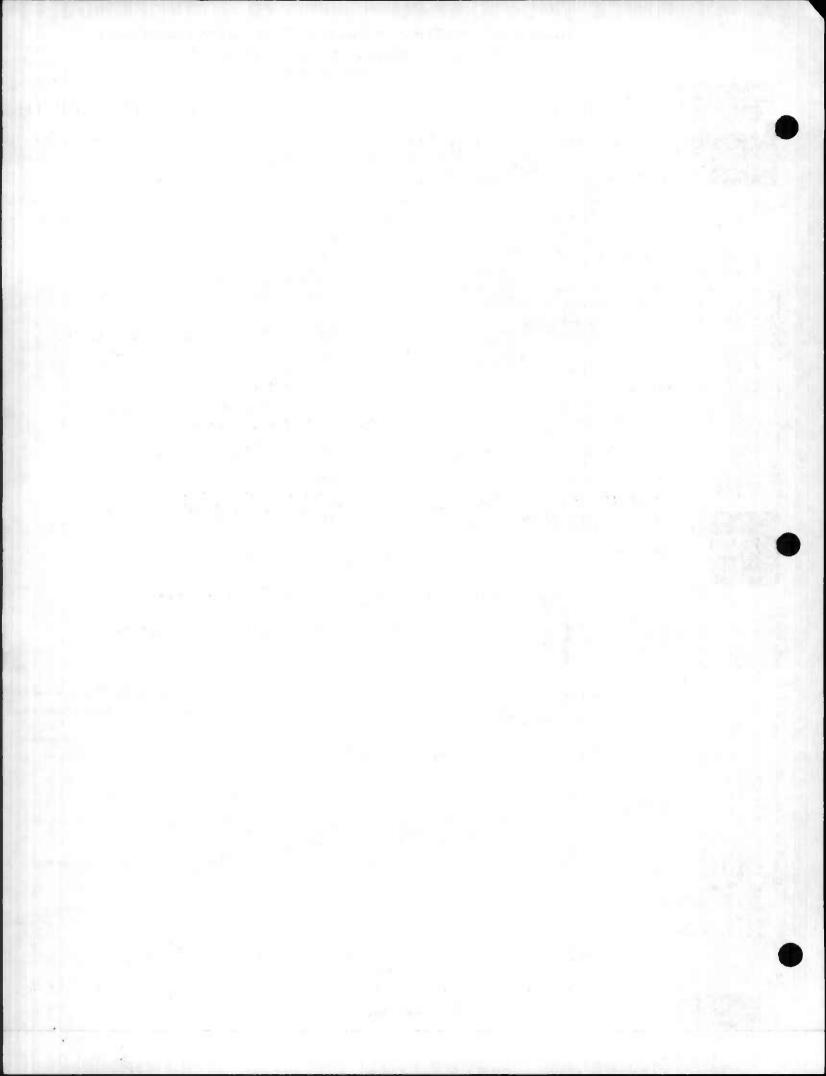
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GOLDMAN Cherry Lane MD 8317

State Registrar

Medical

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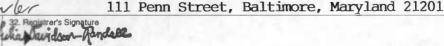
29b. Signature and title of certitier

31. Date tiled (Month, Day, Year)

26

1998

30. Name and address of parson who completed cause ot death (Item 23a) (Type, Print) where



1 Certifying Phyelcien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

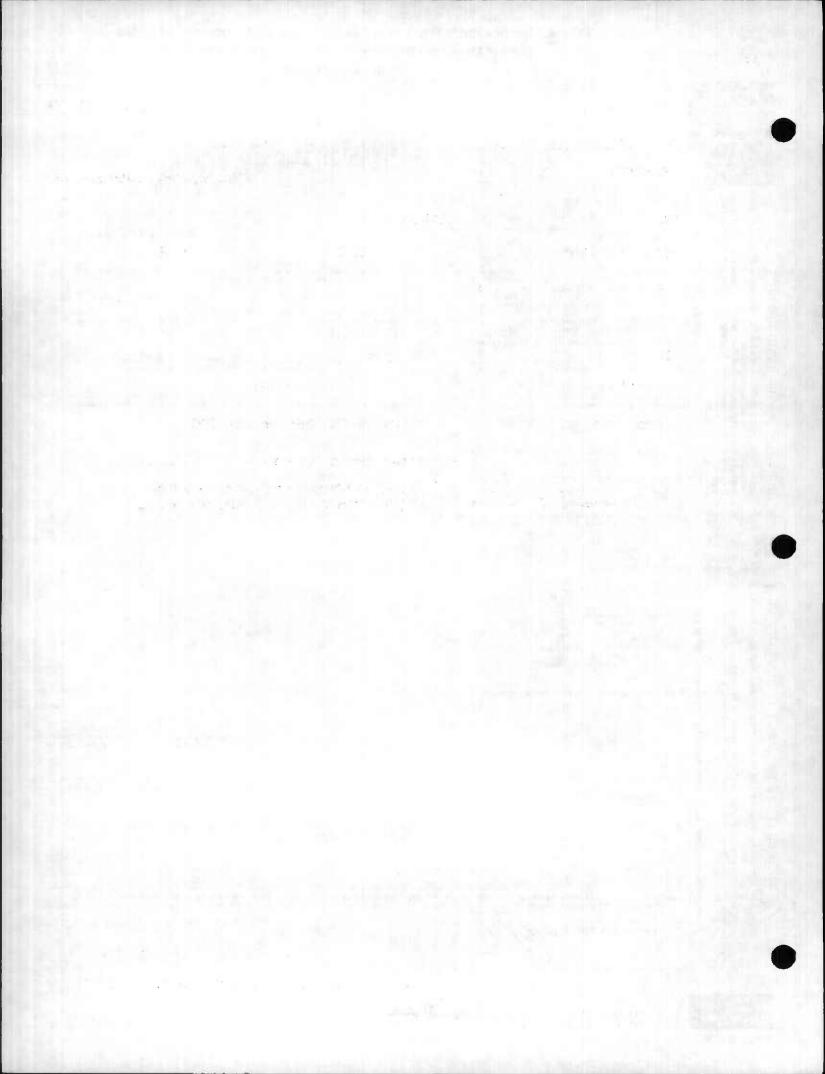
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Dev. Year)

JANUARY 18, 1998



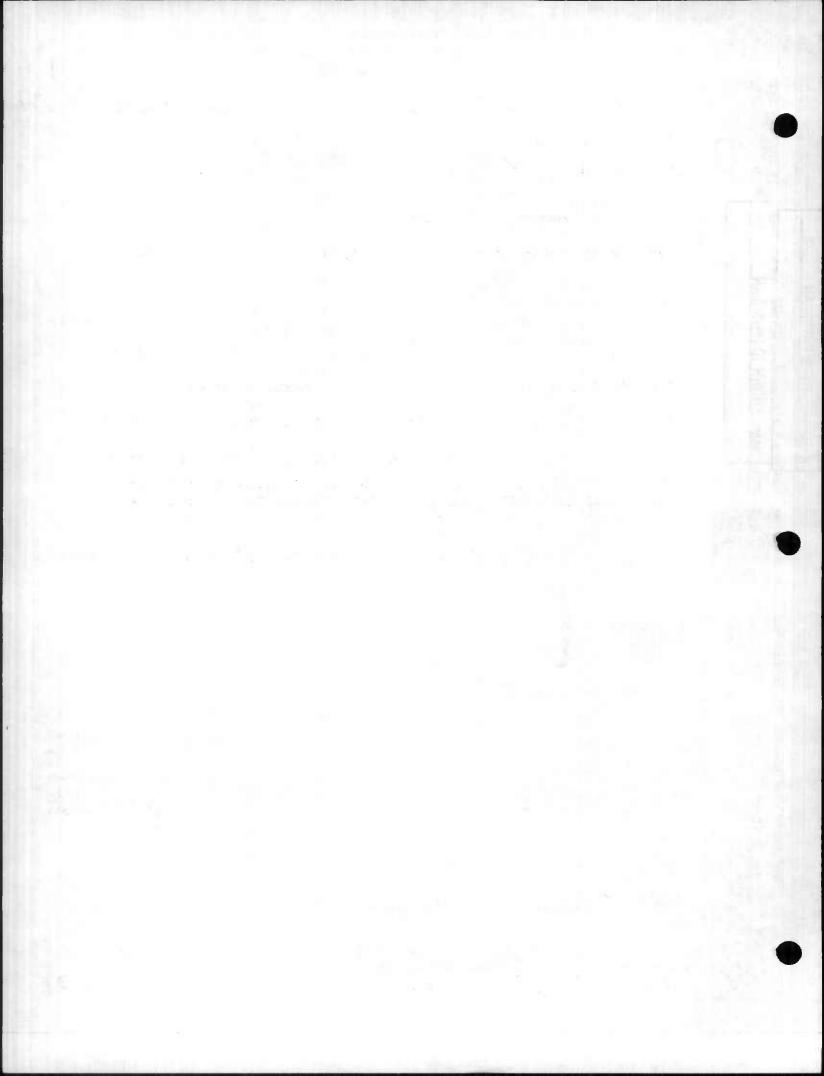
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** LASKES Month 520 PM GNES AN 21,1998 /Medical 4a. Fecility Name (If not Institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Church Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Oct 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 212 F 219-10-2550 88 Yrs. Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 No Edgemere 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4418 North Point Blvd. 21219 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. PROPHYSIGHA 1 Never Married 2 Married ò 1 Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Locke Marianna Glass 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) WANTED John Laskey Jr. / son 4331 Bunny Lane Edgemere, MD 21219 If Nam 27 n 26 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 12 Burial 2 Cremetion 3 Removel from State 1998 Gardens of Faith 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk elt 7110 Sollers Point Rd 21222 23e. Pert1. Enter the discusse, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final · CEREBRO VASCULAR ACCIDENT disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, sign. þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? 1□Yes 2⊡No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) RECOVER Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) CARE Certification: To this 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending efter death. Investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) illed in by 4 Homicide 24 hours e Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. Medicai (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. To the Vithin 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year)

JAN 2 6 1998

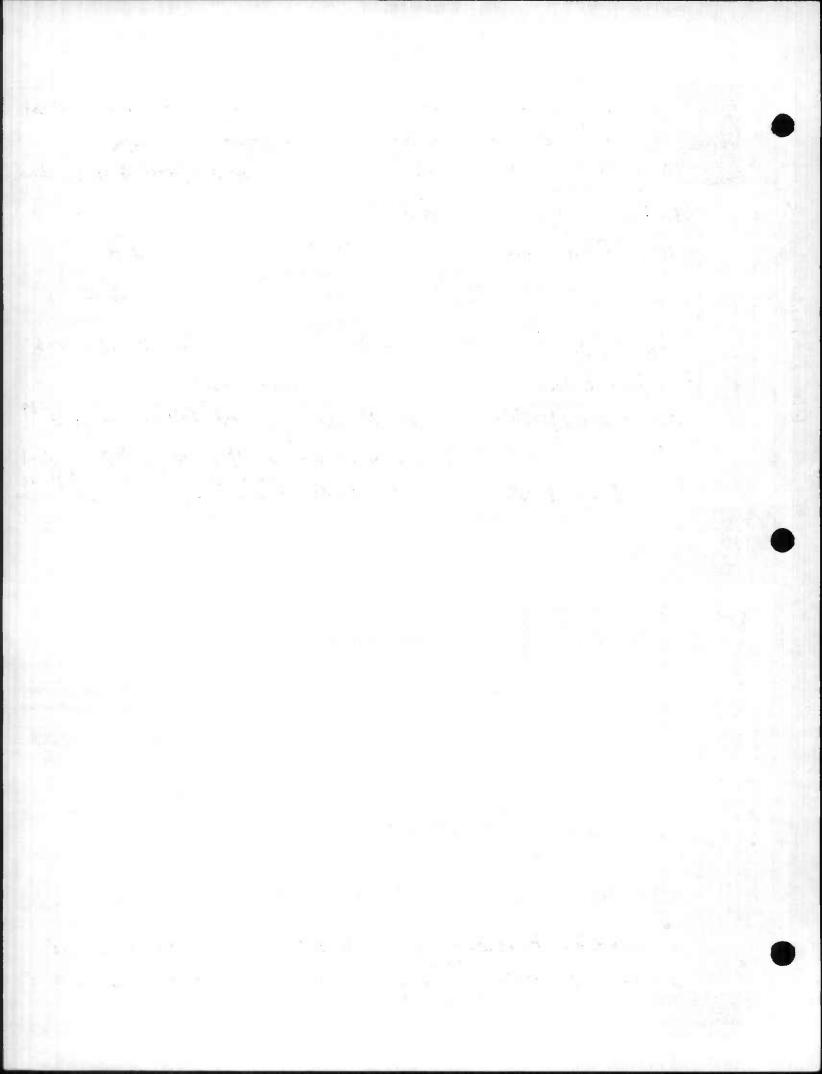
M. D. CHUNCH HOSPIAL. BALT. MD 21231 32. Registrer's Signeture Julia Sairdson-Randalle

KNOWN TO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 6 5 2 Certificate of Death Reg. No.

. Social Security Number 6. Sa	Ave. 10c. Ci Ave. 112. Wes Decedent Ever in Larmed Forces? 1 Yes, Give Yeer or Dates: ucation 12 College (1-4or 5+) 12 College (1-4or 5+) 13 College (1-4or 5+) 14 College (1-4or 5+)	Inst birthday) (ast birthday) (b) Yrs. Ity, Town, or Loc Ity, Town,	If Under 1 Year Months Days cation VIC 10f. Zip Coda Z/Z Vas Decedant of H Yes, specify Cubs Yes, specify Cubs Yes 2 No ent's Usuel Occup kind of work done NO NOT use retired g Address (Street No Not use retired To VIC Nama and Addra SIZ Fred	If Under 24 Hrs. Hours Min. 15 Hispanic Origin? (Spean, Maxicen, Puarto Specify: Detion during most of working the second Number or Rura Pading for Cem. Iss of Facility Keylerick A	action of Death OCH 8. Dete of Birth (Month, Dey, April 10, 100 100 100 100 100 100 100	22 19 4c. County of All 4c. County of All (ear) 435 5 G. Citizan of Wh L. 14. Race- Biack, Specify: Bib. Kind of Busin Style (LA Biden Sumeme) City or Town, Sh	Birthplace (State or F County) 10d. Inside City I 1 Yes 2 10d. Inside City I 1 Yes 2
Levindak S. Social Security Number 218 - 49 - 3013 Susual Residence of Decedent 10e. Steta 10b. County 10e. Street and Number 4408 Palmer 1. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grad Elementery/Secondery (0-12) 7. Fether's Name (First, Middle, Last) 19a. Informent's Neme/Relationship (7) Betty Bellany 19a. Informent's Neme/Relationship (7) 19a. Informent's Neme/Relationship (7) 19a. Informent's Dellany 21. Signeture of Funeral Service Licens 223e. Pert1. Enter tha disease, or comply shock, or heert feilure. List only or memediate Causa (Final disease or condition	AVE. 12. Wes Decedent Ever in L. Armed Forces? 1	Inst birthday) (ast birthday) (b) Yrs. Ity, Town, or Loc Ity, Town,	If Under 1 Year Months Days cation VIC 10f. Zip Coda Z/Z Vas Decedant of H Yes, specify Cubs Yes, specify Cubs Yes 2 No ent's Usuel Occup kind of work done NO NOT use retired g Address (Street No Not use retired To VIC Nama and Addra SIZ Fred	Bafin If Under 24 Hrs. Hours Min. Is Hours Min. Is Hours Min. Is Hours Min. Is Mother's Name Lena and Number or Rure ording from ce) Vet. Cem. Is of Facility Ken Lena Lena Resident Min.	action of Death OCH 8. Dete of Birth (Month, Dey, April 10, 100 100 100 100 100 100 100	dc. County of All (ear) 935 G. Citizan of Whi L. 14. Race- Black, Specify: Sb. Kind of Busin St. L. City or Town, St. Lity or Town, St. Wings Charles Cha	Deeth A B. Birthplace (State or F County) 10d. Inside City I 11 Yes 2 net Country? SA American Indien, Whita, atc. Black nass/Industry ited Churce tele, Zip Code) Maryland ity or Town, State Mills, Maryl Maryland Approximate
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1 ☐ Yes 2 No	1/5/Inpatient 2L		3LI DUA	4 Unursing Ho			
1) Netural 5 Pending Investigation		28b. Time of Injury			28d. Describe now	injury occurred	
4 Homicide determined	208. Pleca of injury - At n	nome, farm, stre	eet, fectory, office	1	28f. Location (Stree City or Town, 1	et end Number Stete)	or Rural Route Number
Pa. Cartifier (Check only one) Certifying Physical Exami	sician: To the best of my kno iner: On the basis of examine and menner stated.	owledge, deeth etion end/or Inv	occurred at the tin estigation, in my o	ma, date and placa, e plnion, deeth occurre	end due to the caused at the time, date	se(s) end mann a and piece, and	iar as stated. d due to the cause(s)
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mostles	whitney	COM	D 43	5757	J	AN 2	-2,1998
O. Name and address of person who or	ompleted cause of deal filer	m 23a) (Type, F	Print)				
77	5. Wes case referred to medical examiner? 1 Yes 2 No 7. Menner of Death 1 Netural 5 Pending investigation 3 Suicida 6 Could not be determined 4 Homicide Gertifying Phy (Check only one) 2 Medical Examone) 9a. Cartifler (Check only one) Medical Examone) 9b. Signature end title of cartifler	5. Wes case referred to medical examiner? 1 Yes 2 No	5. Wes case referred to medical examiner? 1 Yes 2 No	5. Wes case referred to medical examiner? 1 Yes 2 No	5. Wes case referred to medical examiner? 1 Yes 2 No	24e. Wes en performed to medical examiner? 1 Yes Yes	24e. Wes en autopsy performed? 1 Yes 2 No 5. Wes case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 5. Wes case referred to medical examiner? 1 Yes 2 No 26. Place of Deeth (Check only one) 1 Yes 2 No 27. Menner of Death Yes 2 No 28a. Date of injury (Month, Dey Year) Yes 2 No 28a. Date of injury - At home, farm, street, fectory, office 28d. Describe how injury occurred work? Yes 2 No 28d. Location (Street and Number City or Town, Stete)



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The second contract of

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate by geocyaed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memail Hygiene prior to benial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF	HEALTH	AND	MENTAL	HYGIENE	
CERTIFICATI	E O	F DEAT	TH		DEG NO	

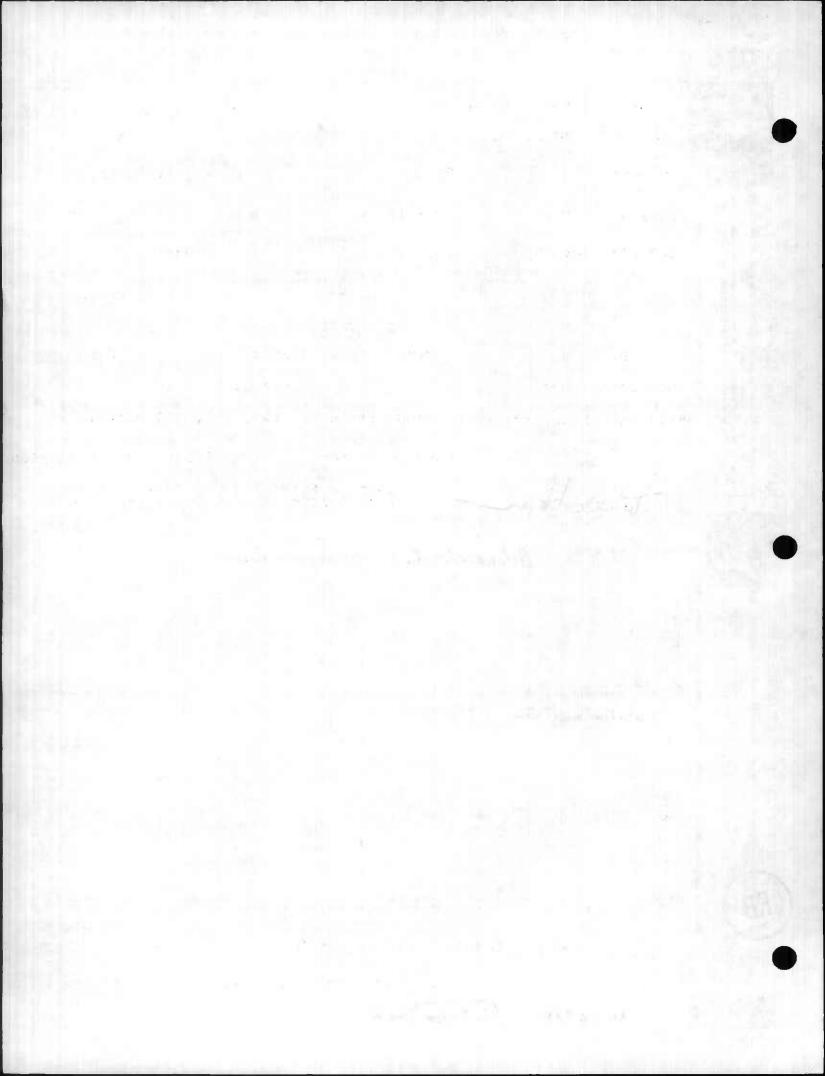
E STRAR	STATE OF MARYI		E OF DEATH	MENTAL HYGI		
IT'S NAME (First, Middle, Last)				2. DATE OF DEATH	1	3. TIME OF DEATH
MARIE	N.	MERCE	FR	MONTH TAN	20 /	798 8:05 PM
34-9383	5. SEX 6. AGE	(In yrs. last birthday) IF UND	ER 1 YEAR F UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea	1	BIRTHPLACE (State or Foreign Country)
rest Have	- M	. 11	Catonsvi		Sc. COUNT	y of DEATH
10b. COUNTY	11:	10c. CITY, TOWN	OR LOCATION			10d. INSIDE CITY LIMITS?
T AND NUMBER	utimore	2 La	TONSVILLE 101. ZIP CODE	,	10g. CITIZI	1 VES 2 NO
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Married 2 Married	FORCES? 1 YES	2 NO	If yes, specify Cuben, Mexic	en, Puerto Rican, atc.		4. RACE — American Indian, Black, White, etc. Specify: Black
(Specify only highest grade of	completed)	(Give kind of work don	e during most of working	16b. KIND OF	BUSINESS/INDU	STRY
th grades	College (1-4 or 5+)	Domes	stic	0,	un H	ome,
NAME (First, Middle, Last)	20		16. MOTHER'S N	AME (First, Middle, Mai	den Sumame)	Carroa
IANT'S NAME (Type/Print)	Wilson	19b. MAILINO ADDRE	SS (Street and Number or Rural	Route Number, City or	Town, State, Zip C	code)
D OF DISPOSITION 2 Cremation 3 Remon	val from State			DATE 20c	LOCATION — CI	en laryand 221
on 8 Other (Specify)		M+ Xi	in Cenuser	41-24-98	ansdou	ne, Maryland
Sharron &	1 Bout		Joseph H. B	A	Δ .	rai Home Pa.
I. Enter the diseases, or co	omplications that cause	d the death. Do not ente	er the mode of dying, su	ch as cardiec or re	epiratory arres	it, Approximate
E CAUSE (Final r condition	BREAS	T CAN	CER			Interval Between Onset and Death
	DUE TO (OR AS	A CONSEQUENCE OF):				
ding to immediate	DUE TO (OR AS	A CONSEQUENCE OF):				
ter UNDERLYING						
lsease or injury c.	DUE TO (OR AS	A CONSEQUENCE OF):				
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	NCE OF DECEDENT 10b. COUNTY 1	T AND NUMBER 10b. COUNTY 10b. COUNTY 11c. WAS DECEDENT EPORCES? 1 YES 11c. WAS DECEDENT EVER. PORCES? 1 YES 11c. WAS DECEDENT EVER. PORCES? 1 YES If YES, GIVE WAR OR IT 11c. DECEDENT'S EDUCATION (Specify only highest grade completed) 11c. DECEDENT EVER. 11c. DECEDENT EVE	SECURITY NUMBER S. SEX Color Col	S. SEX 34 - 98 8 1 M M S F 70 YRS. 1 M 2 F 70 YRS. 1 MONTHS DAYS HOURS MAIN. YRS. 9b. CITY, TOWN OR LOCATION OF C CATON OF LOCATION 10b. COUNTY 10b. COUNTY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10f. ZIP CODE 2 1 M Married 10f. ZIP CODE 2 1 M M S DECEDENT OF HISPA 10f. VES 2 NO Spec 10f. ZIP CODE 2 1 M M S DECEDENT OF HISPA 10f. VES 2 NO Spec 10f. ZIP CODE 2 1 M M S DECEDENT OF HISPA 11 M S DECEDENT OF HISPA 12 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO Spec 13. WAS DECEDENT OF HISPA 14 M S DECEDENT OF HISPA 15 WAS DECEDENT OF HISPA 16 NOTHER'S NO Spec 17 W S 2 NO Spec 18 NAME (First, Middle, Last) 19b. MAILINO ADDRESS (Street and Number or Rural 19c. DECEDENT OF DISPOSITION (Name of composition) 19c. MAILINO ADDRESS (Street and Number or Rural 19c. MAILINO ADDRESS (Street and Number or Rura	SECURITY NUMBER 3. SEX 0. AGE (In yrs. list Dithiday) 1	SECURITY NUMBER 34-98-81 M 2

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Physician					(Certificate (of Dea	th	_	Reg. No.	3 0	1654
	1. Decedent's Name (First,			C					2. Dete of De Month	Day	Year	3. Time of Deeth
/Medical	пенту п						4h City	Town or L	JAN.	23, 19	98 ty of Death	11:45 A
Examiner	ST. AGNES							LTIMOF			V/A	
Funeral Director	5. Social Security Number 215-22-808		Gex. 1☐M 2☐F		yrs. last birthe	Months De	ear If Un	der 24 Hrs. rs Min.	8. Date of Bir (Month, De July	th 7,1928	Cour	place (State or Foreigntry) 'Yland
,	Usual Residence of Deced			100	04 *-	1 6						
show at	10a. State 10b. C	N/Z	A	100	Balt:	imore					1	0d. Inside City Limit 1
289-	10e. Street and Number					10f. Zip Co	de			10g. Citizen of	f Whet Cour	ntry?
3a or	400 Millin	ngton	n Aven	ue Aj	pt. 2	10 212			2.0	United		
nd Mantal Hygiana. marked other than 'natural', or items 23s or 28s-f show imatic event, the Medical Examinet must be notified at TO Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Div		12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 No ive	in U,S.	13. Was Decedent If Yes, specify			ecify Yes or No Ricen, etc.)	BI	ace - Americ ack, White, ify: Whi	etc.
natura pted	15. De	cedent's E	ducetion ede com <i>pleted</i>		16a. D	ecedent's Usual O	ccupation	nost of work	rina	16b. Kind of	Business/In	dustry
other than "naturn ent, me Medical ent e Completed	Elementery/Secondary (1		1-4or 5+)	1	ife. DO NOT use re	etired)			0:+	D-	1.6.1
Hygia ther th	17. Father's Neme (First, N	fiddle. Last	')		prav	w Bridge			e (First, Middle	, Maiden Sume		ltimore
Antal H arked out aftic even	1								E. Hen			
0 0	19e. Informant's Name/Rei Elizabeth			wife		Mailing Address (Si						code21223
of Health Item 27	20a. Method of Disposition				Ob. Place of C	Disposition (Neme of crematory or other	of place)		Date	20c. Location	- City or To	own, State
Tr. H	1 Burial 2 Crem 4 Donation 5 Ot			State		Cremate		1	/28/98	Catons	svill	e,Maryl
ysician Medical caminer	23a. Part1. Enter the dises shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	ase, or com ase, List only		iosci	lerotic	Ambrose 1328 St t enter the mode of Cauchov nsequence of):	ulphu dying, such	r Sp	ring R	load i		Arbutus and 212 Approximate Interval Between Onset and Death
nin nin		•	b	Due	to (or es a co							
iding physician and usa as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Lest	{	c		to (or as a cor	nsequence of):						
tha bur dicai	Cause (Disease or injury that initiated events resulting in death) Lest	ι	d.	Due		nsequence of):	e civen in P	art I	23h Did	Ториссо мая с	contribute t	o the cause of deat
tha bur dicai	Cause (Disease or injury that initiated events resulting in death) Lest	onditions of		Due		nsequence of):	e given in P	art I.	1			
tha bur dicai	Cause (Disease or injury that initiated events resulting in death) Lest	onditions of		Due		nsequence of):	e given in P	art I.	1 □		3 ☐ Pro	bably 4 Unknown
is been signed by the attending physicia 2 should be datached for use as the but pleted by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Lest	onditions of		Due		nsequence of):	e given in P	art I.	1 = 24a. Wes	Yes 2 No	3 Pro	ere eutopsy finding- ailable prior to impletion of ceuse deeth?
is been signed by the attending physicia 2 should be datached for use as the but pleted by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other algnificant co	mel)		Due		nsequence of):			1 = 24a. Wes perf	Yes 2 No s en eutopsy ormed? Yes 2 No	3 Pro	bably 4 Unknown
cartificate has been signed by the attanding physicie rector, page 2 should be datached for use as the but Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant or Dark Section 25. Was cese referred to mexaminer?	mel)	Litus	Due leath but no		nsequence of): he underlying caus	26. F	lece of Dea	24a. Wes perf	Yes 2 No s en eutopsy ormed? Yes 2 No	24b. W av cc of	tere eutopsy finding vailable prior to impletion of ceuse deeth?
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his cartificate has been signed by the attanding physicie if director, page 2 should be datached for use as the but To Be Completed by Physician/Medical	Cause (Disease of injury that initiated events resulting in death) Lest Part II. Other algnificant or examiner? XX Yes 2 No 27. Menner of Deeth 1 Naturel 5 1 2 Accident 3 Suicide 6 0 4 Homicide 29a. Certifier 1 Car (Check only one)	onditions of multiple and medical pending investigation Could not be determined artifying Ph	Hospitel: 1 28a. Date (Mor	Inpatient of Injury th. Dey Yea	2 Re/Outp ar) 28b. Tin Inju At home, farm pecify)	nsequence of): the underlying caus tatient 3 DOA ne of 28c.	26. F Other: 4 Injury et Work? 1 Yes	lece of Dea	24a. Wesperf 1	Yes 2 No sen eutopsy ormed? Yes 2 No one) idence 6 C how injury occ (Street end Nur wwn, Stete)	24b. Way or of 11	mpletion of ceuse deeth? Yes 2 No

Registrar

JAN 26 1998 Shir Devidon Rondole



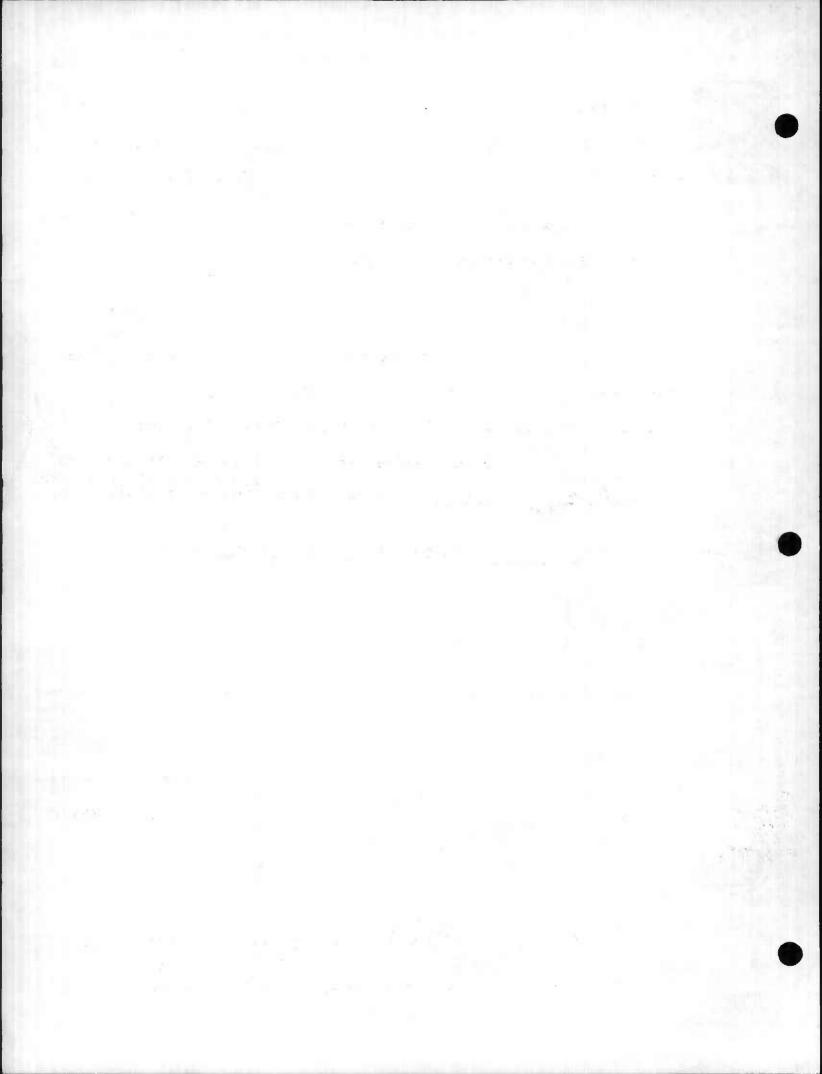
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

					Cei	rtificat	e of	Death			Reg. No.	0	01000	J
	Discolotore	1. Decedent's Name (First, Middle,								2. Date of D		Ye	3. Time o	
ш	Physician /Medical	Cutilitie D.	Madden						J	ANYAR	A 53	, 198	8 5:43	AM :
	Examiner	An Finallia, Name of Sant Inntitution	give street and num Medica	l Cent	er				wn, or Lo	ocation of Dea	th 4c.	County of D	eath ltimore	
	Funeral Director	5. Social Security Number 214-38-2774	6. Sex 1 □ M X ▼ F	7. Age (In yrs. 95	lest birthday) Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Bi (Month, D Feb.	irth Year) 22,1	9. 1902 M	Birthplace (State Country)	or Foreign
	pu &	Usual Residence of Decedent 10a. Stete 10b. County		10c City	y, Town or Lo	cation							10d. Inside C	Site I imite
	the Maryler 28s-f show	Md. Baltin	more		ockeys	sville							1 ☐ Yes	25%
	ifier death with the Maryland ritems 23s or 28s-f show ifier must be notified at funeral Director	10e. Street and Number 14323 Cuba Road		30.5		10f. Zip		1030			10g. Citi	zen of What USA		
21215-0020	or setter francing by Fu	3 X Divorced 4 □ Divorced	Armed For	१ ∰ No e		Was Deced if Yes, spec 1 ☐ Yes		lispanic Orig an, Mexicen Specify:	gin? (Spe , Puerto	ecify Yes or N Ricen, etc.)	0-	Black, W	merican Indian, Vhite, etc. Black	
5-0	72 h	15. Decedent's (Specify only highest	s Education grade completed)		16a. Deced	kind of wo	rk done	during most	of worki	ing		nd of Busine		
121	offied within 72 hours of Hygiena. other than "natural", vent, the Medical Existence in the Medi	Elementary/Secondary (0-12)	College (1 20+	-4or 5+)	Schoo	DO NOT us	se retire	d)					County	
	Hygie Co.	17. Fether's Neme (First, Middle, L			benoe)	IIICI	_	r's Name	e (First Middle			unknown	
lan	Mantel H Marked out arked out	William Smith						Annie		(1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	04.114.710)	dikilowii	
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mantel Hygiena. Important: If item 27 is marked other than "naturn any injury or other traumatic event, I'm Medical once. To Be Completed	19a. Informent's Name/Relationsh Beverly Henry	ip (Type, Print) n	iece						More,			te, Zip Code)	
ē,	Heal Heal tam 2	20a. Method of Disposition		20b. P	Place of Dispo	sition (Nar	n <i>e</i> of			Dete			or Town, State	
OE OE	Pages ant of nt: If i	Murial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Spi		state _	emetery, crer Igh U.N				J	an.29	Cock	cevsvi	lle, Md.	1
Baltimore,	permit. Departm Importa	21. Signature of Funeral Service		B	22	2. Name an	nd Addre	ess of Facility	Nu Nu	tter F	unera	al Hom	es, Inc.	
ı		23a. Part1. Enter the disease, or o shock, or heart feilure. List o	complications man	the death	h. Do not ent	er the mod	le of dyi	ng. such es	cerdiac o	or respiretory	errest.	ore, M	Approxime	ete
	Physician /Medical Examiner	Immediate Cause (Final disease or condition	SEPS	-									Interval Be Onset end 18 D	Death
L	je line	resulting in death)	ASCE	Due to (o	r as a consec CHOLF	uence of):	ris						18 D	AYS
,0	auth certificate be axecuted ettending physician end for use es the buriel-trensit clary/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ь.	Due to (o	r as a conseq	quence of):			П				1	
68760,	ng physicia es the bur	resulting in death) Lest	С	Due to (or	r es e conseq	uence of):								
Box	th certification tending or use e		d											
0.	d by the ettenk etached for us	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the u	nderlying c	ause giv	en in Part I.		23b. Dic	tobacco	use contrib	oute to the cause	of death?
0	= 00		L. Wil							1	Yes 2	DXNo 3	Probably 4] Unknown
ecords	s been s 2 should pieted										s an autop formed?	sy 24	4b. Were autopsy eveilable prior completion of of deeth?	to
R	The is page page									1□	Yes 2	X No	1 □ Yes 25	C No
Vital	ysiclan: The s certificate director, pag	25. Was cese referred to medical examiner?					1		of Death	n (Check only	one)			
of	Z 0 5				ER/Outpatier		JA		-	me 5□Res			Specify)	
	After t funer funer tion:	27. Manner of Death 1 Natural 5 ☐ Pending		n, Dey Year)	28b. Time of Injury	M 2	28c. Injui			28d. Describe	how Injur	y occurred		
Division	or Attano after deat Director: in by the	2 Accident Investige 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At ho ig, etc. (Specify	ome, farm, str			Yes 2□!		28f. Locetion City or To	(Street en own, State	d Number o	r Rurel Route Nur	n <i>ber</i> ,
	To the Hospital within 24 hours a vithin 24 hours of the Funeral completely filled		Physician: To the i xaminer: On the ba and mann	sls of exeminet	wledge, death tion and/or Inv	occurred vestigation	at the ti	me, date and opinion, deat	d place, oth occurr	end due to the ed at the time	e cause(s) , date and	and menne I place, and	r es stated. due to the cause((s)
	within To the comp	29b. Signeture and title of certifier	4.0	M	7	290		se number			29d. Dat	signed (M	nth, Day, Year)	
	VA.	Imol	y For	w.//1.	V.	D	240	134			11	23/	98	
	0,0	30. Name and address of person w					elgen gem r	Im mt :		m			1	
	1.			520 YO		IAD,	TOV	ISON,	MA	RYLANI	D 5	1204		T.F.
	State	31. Date filed (Month, Pay, Year)	32. F	gistrar's Signa	ture	J. ne								

e creamed and the

State of Maryland / Department of Health and Mental Hygiene 8 0 1 6 5 6

			Certificate	of Death	Re	g. No.	01000
Physician	1. Decedent's Name (First, Middle, Las	t)			A. Date of Death		3. Time of Death
/Medical	MARGARET		MILLER		HANUARY	23 /	998 44
Examiner	4e. Facility Name (If not institution, give			4b. City, Town, or L		4c. County of	
	Stella Maris I		lest highday) If Under 1 Y	Timonium Tear If Under 24 Hrs.		Balt	
uneral irector		M 2 N F 7 8	Months D	ays Hours Min.	8. Date of Birth (Month, Day, Feb. 22	Year) 19191	9. Birthplace (State or Foreign Country) Maryland
WOT III	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
a-f si	Maryland Balt	imore Ca	atonsville				1 ☐ Yes 2 💆 No
or 20	10e. Street end Number		10f. Zip Co	de	10	g. Citizen of Wh	nat Country?
ral [13 North Beaum	ont Avenue	2122	8		U.S.A	A .
Daminer must be notified at by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	,S. 13. Was Decedent If Yes, specify 1 ☐ Yes 2 🗷	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)		- Americen Indian, White, etc.
	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				1	White
t, he Medical Ex-	15. Decedent's Ed (Specify only highest gree	de completed)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use re	ccupation one during most of work	ring 1	6b. Kind of Busi	iness/Industry imore County
Ju du	Elementery/Secondary (0-12)	College (1-4or 5+)					_
matic event, the M	17. Father's Name (First, Middle, Last)	4	Public Nur		e (First, Middle, Ma		System
To Be	Frank Dello					· ·	
T T	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (St		eth Rizz		tate. Zip Code)
important: if item 27 is marked other than "natur any injury or other traumatic event, I'm Medical pace. To Be Completed	Marie DiCesare 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	20b. F Removal from State	Place of Disposition (Name of cemetery, crematory or other	of place)	Date 20	Oc. Location - C	lle MD 21228 ity or Town, State more, MD
any Inju	21. Signature of Funeral Service Licens		22. Name and A		itzke Fu	neral	Home, Inc.
es the burial-trensit as the horial-trensit Aedical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. — Due to (c	tastatic or as a consequence of): or as a consequence of): or as a consequence of):	hug	Cance	U	Onset end Death
or use	Part II. Other eignificant conditions co	d	ulting in the underfying caus	e given in Part I.	23h. Did tob	acco use contr	ibute to the cause of death?
be detached i							B ☐ Probably 4 ☐ Unknown
2 should					24a. Was an performe		24b. Were autopsy findings available prior to completion of cause of death?
Com					1 ☐ Yes	2 🖪 No	1 ☐ Yes 2 ☐ No
director, pag	25. Was case referred to medical examiner?	Haspital:			th (Check only one,)	
cation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)		Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No	ome 5 Residen 28d. Describe how		(Specify,HOSPICE
Shrifto	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, off	lice	28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
Medical	29a. Certifier (Check only one) CertifyIng Phy	siclen: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occurred at the	ne time, date end place, ny opinion, death occurr	end due to the cau red at the time, dat	se(s) and manr e and place, an	ner es stated. d due to the cause(s)
Comp	29b. Signature end title of certifier	vand	29c. Lie	SULLI ZE	290	d. Dete signed (Monty, pay, Year)
	30. Name and address of person who could be a penetrope of penetrope DW		n 23a) (Type, Print) LANEY VALLEY	DD TIMON	IUM, MD 2	11003	/
State Registrar	31. Dete filed (Month, Day, Year) JAN 2.6 199	32. Registrar's Signa	ture Rendell	NU. ITHUN	TOTE THE	.10.73	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

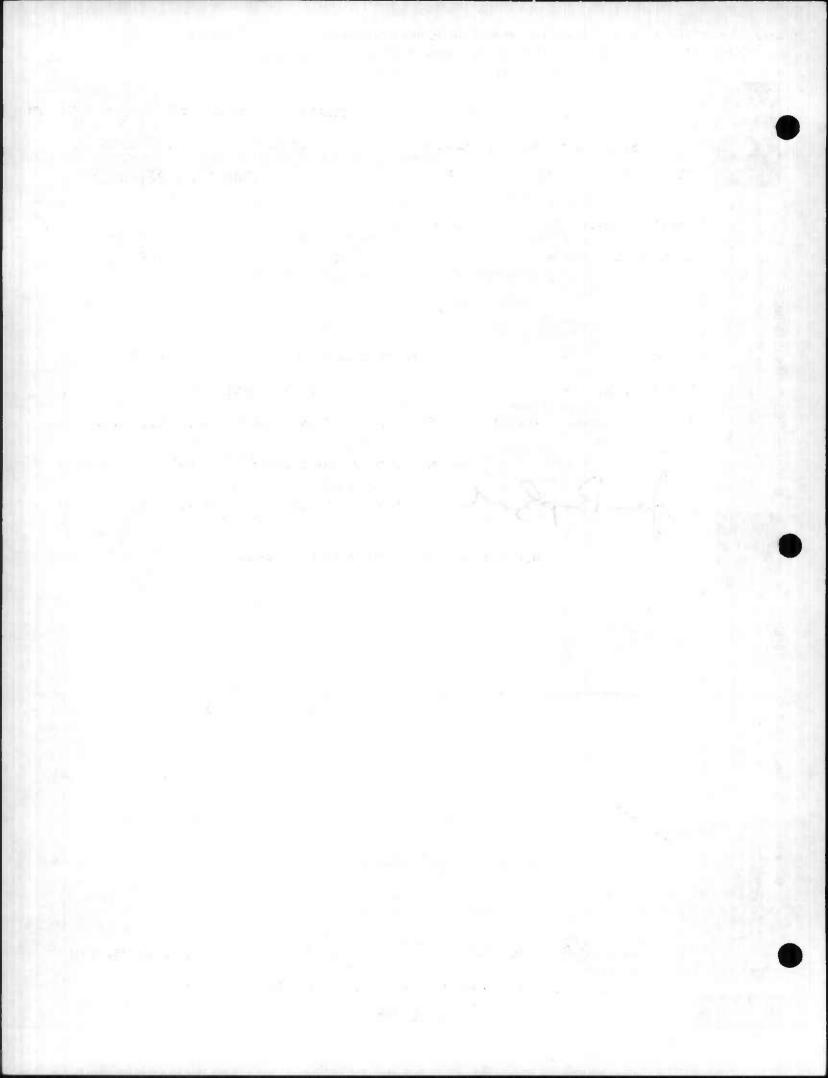
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death with the Maryland	Funeral Director	10e. Street end Number 7011 Bank Str	eet		10f.	Zip Code 2122	.4		10g. Citizen of USA	Whet Countr	y?
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Page nanto any or		20e. Method of Disposition 1			of Disposition (a cremetory of Lawn C			an 26	20c. Location Balti		
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The ate h	Com		1 36					10	Yes 2 No	10	Yes 2□ No
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral	Certification:	3 Suicide 6 Could not b	28e. Plece of Injubuilding, etc	ury - At home, for (Specify)	erm, street, fec	tory, office			(Street end Numb own, Stete)	oer or Rural i	Poute Number,
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13		30. Neme and eddress of person who ABDALCAH J. HELO		eeth (Item 23a)	(Type, Print)				MD 21		
Sta Registr		31. Dete filed (Month, Day, Year) JAN 2 6 199		er's Signeture	Budon		•				

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State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 23,1998 PRZYWARA January 9:21 PM/Medical Leonard Anthony 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Baltimore Rosedale If Under 1 Yeer If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** 1₽M 2□F Deys Yrs. Director 212 22, 6069 June 12, 1926 Maryland Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiena. The marked other than "natural", or items 23s or 28s4 show traumstic event, the Medical Exertine front to routled at 10d, inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 56 Left Wing Drive 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 (XYes 2 □ No if Yes, Give Year or Detes: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Tractor Operator Steel Mill 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Thomas Przywara Sophia Holewinski 2 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Alice A. Przywara (wife) 56 Left Wing Drive Middle River, Maryland 21220 20b. Piece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Locetion - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Of Jesus 1/26/1998 Baltimore County, Md Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Essex, Maryland 21221 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Atherosclerotic Cardiovascular Disease 30 Years Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that inItieled events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): signed by the atte P.O. Part il. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? Yes 2□ No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy peen has page 2 mis certificata 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 20 ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyeictan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Yeer) D35363 January 23, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9000 Franklin Square Dr. Balto, Md. 21237 Mark Himmelheber MD. egistraria Signature State Registrar



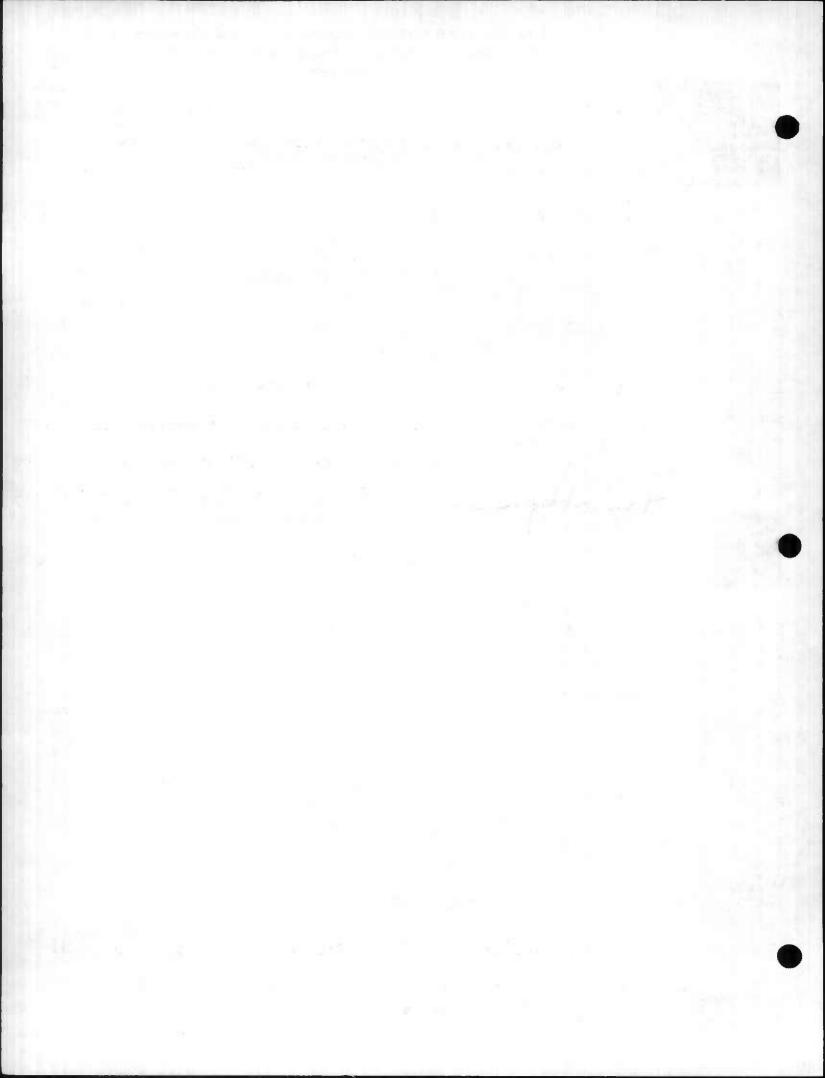
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vea **Physician** Howard J January 1135 24 1998 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore Baltimore Veteran's Administration Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 19 17, 1911 6. Sex 1□ M 2□ F 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 86 215-05-3876 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show soics! Examiner must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5233 Benson Avenue 21227 United States death v Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 X Yes 2 No 9/43
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 21 No Specify: þ Specify: white 9/45 3 Widowed 4 Divorced Year or Dates: Completed th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Used Car Salesman Auto Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Heaith and Mental H Be Frank Charles Popp Elizabeth Szech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Popp, wife item 2. 5233 Benson Avenue Baltimore, Maryland21227 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 12 Burial 2 Cremation 3 Remove from State = 0 permit. Pag Department Important: If any injury o 1/27/98 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 21. Signature of Epopral-Service Licensee 22. Name end Address of Facility Ambrose Funeral Home, In 1328 Sulphur Spring Road Inc. Arbutus Maryland21227 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cluse on each line. Approximate Interval Betw **Physician** /Medical Immediate Cause (Final Pneumonia disease or condition resulting in death) 14 days Examiner Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician s the burial Physician/Medical Due to (or as a consequenca of): as esn ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 s certificate has 1 ☐ Yes 2 No 1 Tyes 2 No notes of Attending Physician:
The atter death.
Director: After this certification by the funeral director, in by the funeral director, in 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☼ npatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2€ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 表記 (Check only one) With To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 24, 1998 710224 mo 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) BVAH Baltimore, MD 21201 Elizabeth Staller, mo 22 N. Greene Street 31. Dete filed (Month, Day, Year) State JAN 26 1998

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth CHARLES J. PARKER Month 2:42 pm 98 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MORE n/a 7. Age (In yrs. last birthday) scurity Num Birthplace (State or Foreign Country) (Month, Day, Year) 10M 20 F Months Days 72 Yrs. 24 0594 March 8, 1925 South Carolina Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Dunda1k 1 Yes 2 No 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 3316 McShane Way 21222 United States 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 9 Department Store Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Carl Parker Effie Sweat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Parker / Son 1753 Brookview Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory 1/26/98 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD and Xokeman 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final PNEUMONIA 5 DAYS disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): thet initiated events resulting in deeth) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 CNo 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24e. Wes an autopsy performed? CEREBROVASCUCAR ACCIDENT ABDOMINAL ADRTIC ANEURYSMY 1 Nes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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the

death

Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiena.

Il Hygiena.

of Health and N

Department of H Important: If Ite any Injury or of once.

Maryland 21215-0020

altimore,

Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

The law requires that the death certificate be executed ed by the attending physician end deteched for use as the burial-trans P.O. Box 68760, signed by t

Physician/Medical

by

Completed

Be

2

Certification:

Medicai

2 Accident

3 ☐ Sulcide

29a. Certifier (Check only

4 Homleide

6 Could not be determined

enrad may MD

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

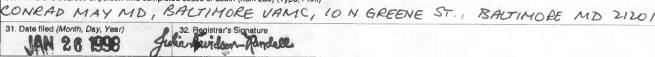
Records, Vital Sion

To the Hospital within 24 hours
To the Funeral completaly filled

X State Registrar

31. Date filed (Month, Day, Year) JAN 26 1998

29b. Signeture and title of certifier



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

29c. License number

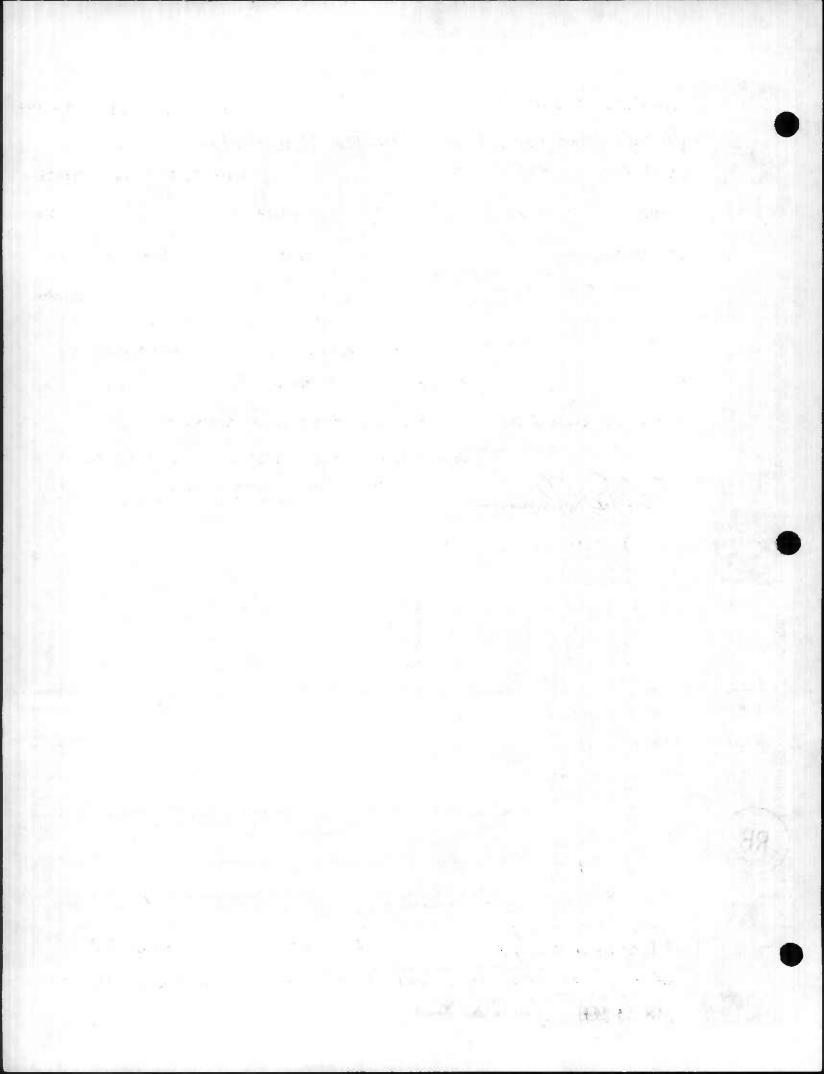
1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

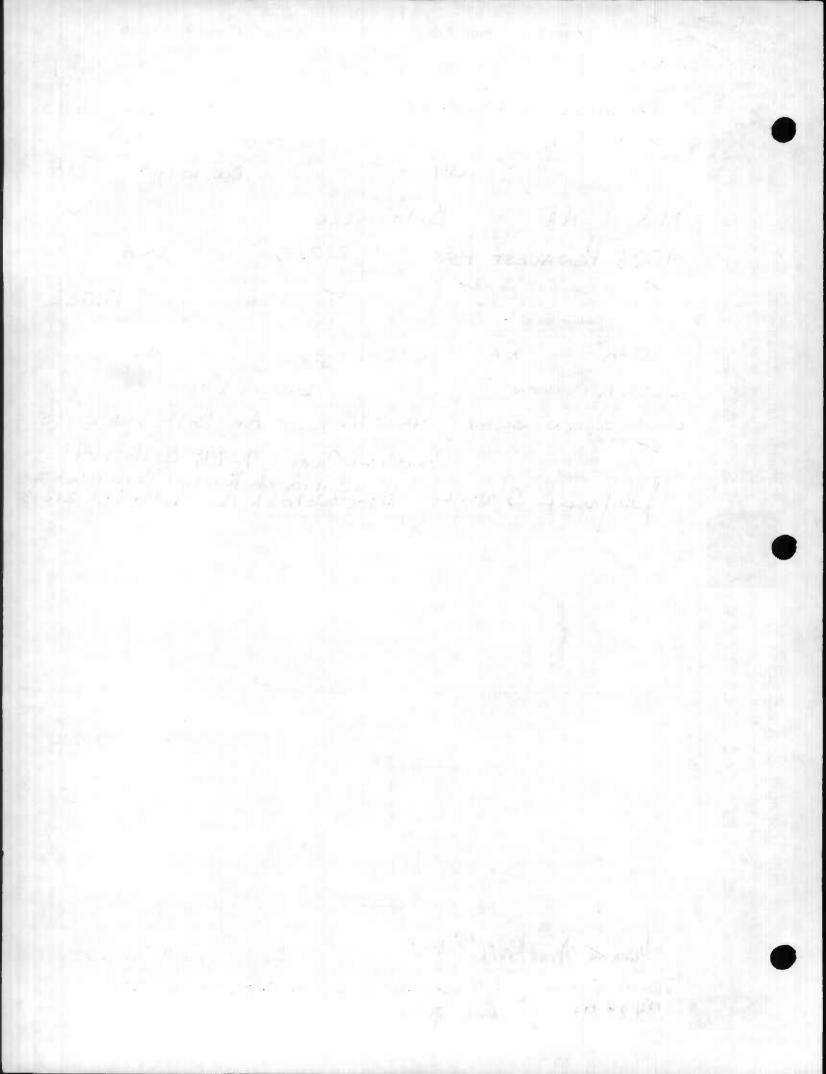
1 Yes 2 No

29d. Date signed (Month, Day, Year)



DHMH 16 Rev 6/95

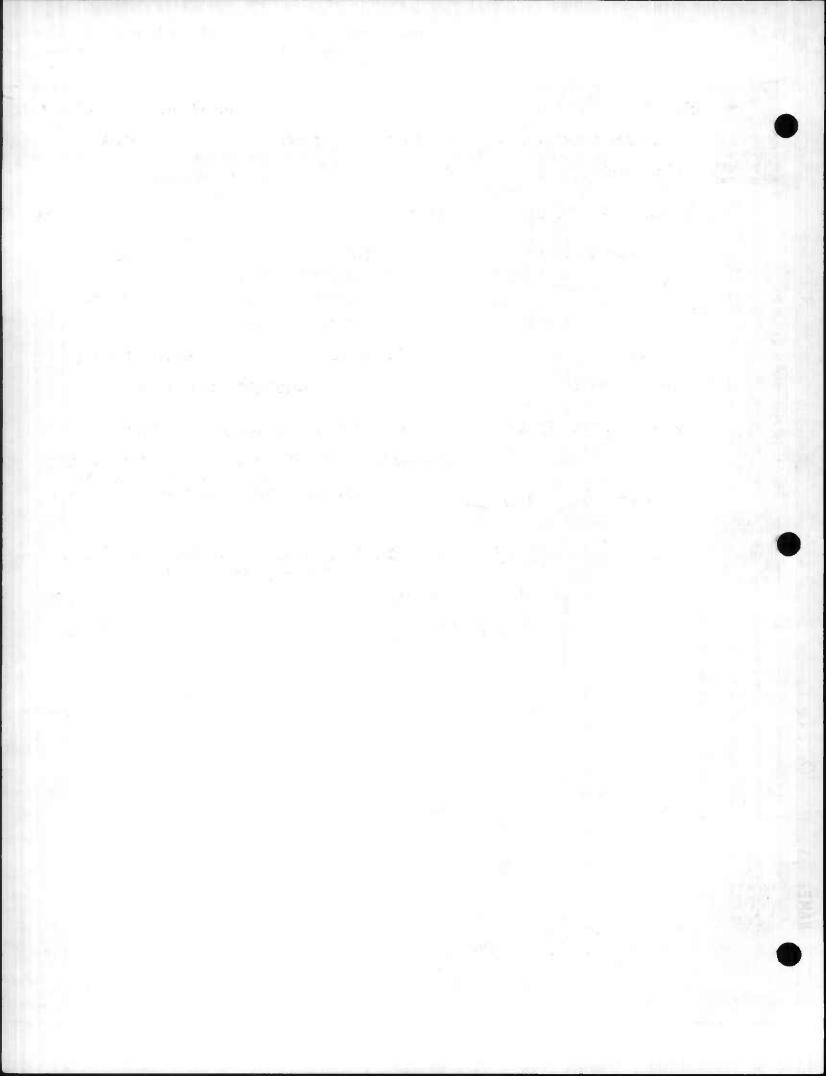
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State of Maryland / Department of Health and Mental Hygiene 8

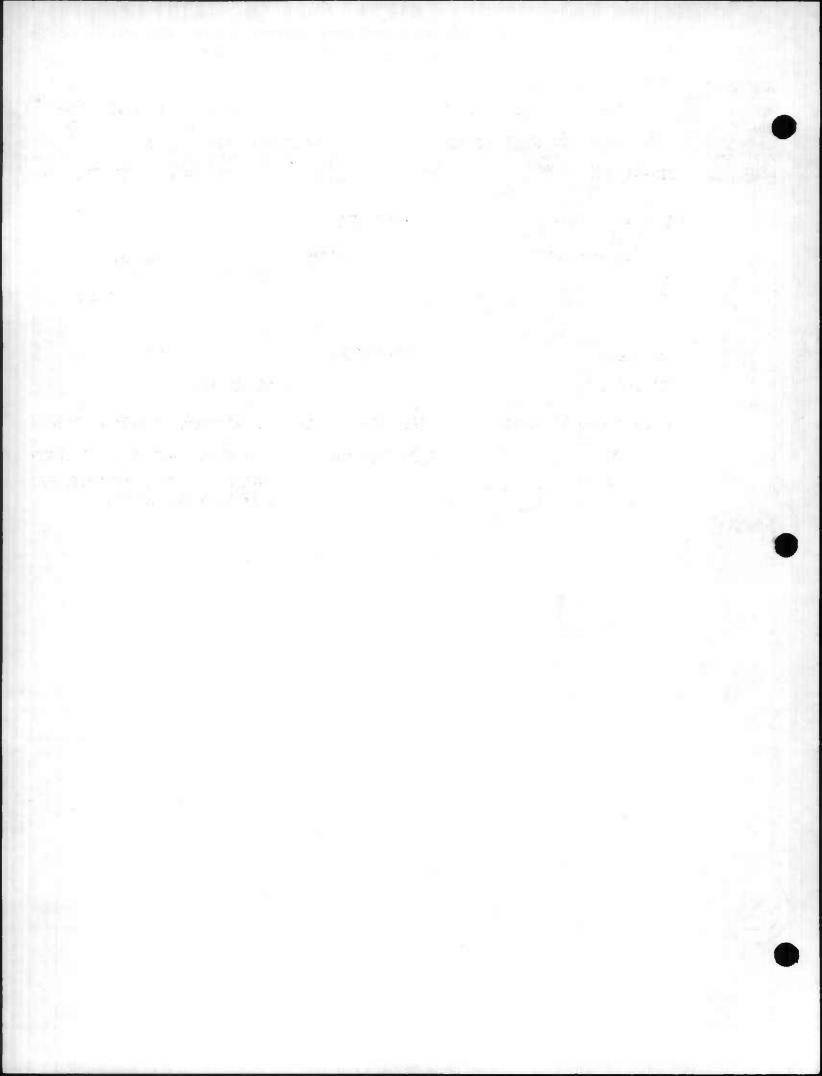
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SAINT AGNES HOSE SAINT AGNES HOSE SAINT AGNES HOSE Social Security Number 215-09-4443 Usual Residence of Decedent 10a. State 10b. County BALTIMO 10e. Street and Number 1114 GREGORY AVE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last DOMENIC RAVITA	PITAL, 900 CA. Sex 1 M 2 F 7. Age (In 8) PRE 1000 1000 1100 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates: Education rade completed) College (1-4or 5+)	yrs. lest birthday 32 Yrs. City, Town or L 3ALTIMOR in U,S. 13.	Months Day Location LE 10f. Zip Code 21207 Was Decedent of lif Yes, specify Cu	BALTIMOR If Under 24 Hrs. S Hours Min. Hispanic Orlgin? (S) ban, Mexican, Puerti	JANUARY ocation of Death E 8. Date of Birth (Month, Day JUL. 16	7 20, 19 4c. County 7 4c. County 7 1915	998 15:45 of Death N A 9. Birthplace (State of Country) U.S.A. 10d. Inside Ci
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19e. Informant's Name/Relationship				ANTOINI	ETTE PON'	TICELLO	
	(Type, Print)	19b. Mai	ling Address (Stree	et and Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zip Code)
ROSE RAVITA,	CTCTFD	111/	CDECODY	A STEDATION T	AT THE MADE		
20a. Method of Disposition		b. Place of Disp	osition (Name of	AVENUE, 1	Date	20c. Location -	LAND 21207 City or Town, State
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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	· Dukel	د!					20 ys
art II. Other significant conditions	dcontributing to death but not	resulting in the	underlying cause g	given In Part I.			
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27. Manner of Death ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time (W		28d. Describe h	ow injury occurr	red
2 ☐ Accident investigation			M 1[Yes 2 No			
2 □ Cuinida 6 □ Could not	28e. Place of Injury - A building, etc. (Sp.	At home, farm, s' ecify)	treet, factory, office	9	28f. Location (S City or Town	treet and Numb n, State)	per or Rural Route Num
3 ☐ Suicide 6 ☐ Could not determine							
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4 ☐ Homicide determined	hysician: To the best of my	knowledge, dea	th occurred at the	time, dete and place	and due to the c	euse(s) and ma	anner as stated.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 12,13,14 Per Meo Film G-755 1-26-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** JAN 725 /Medical 4a. Feclity Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth Examiner Anne Arundel Hospital Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

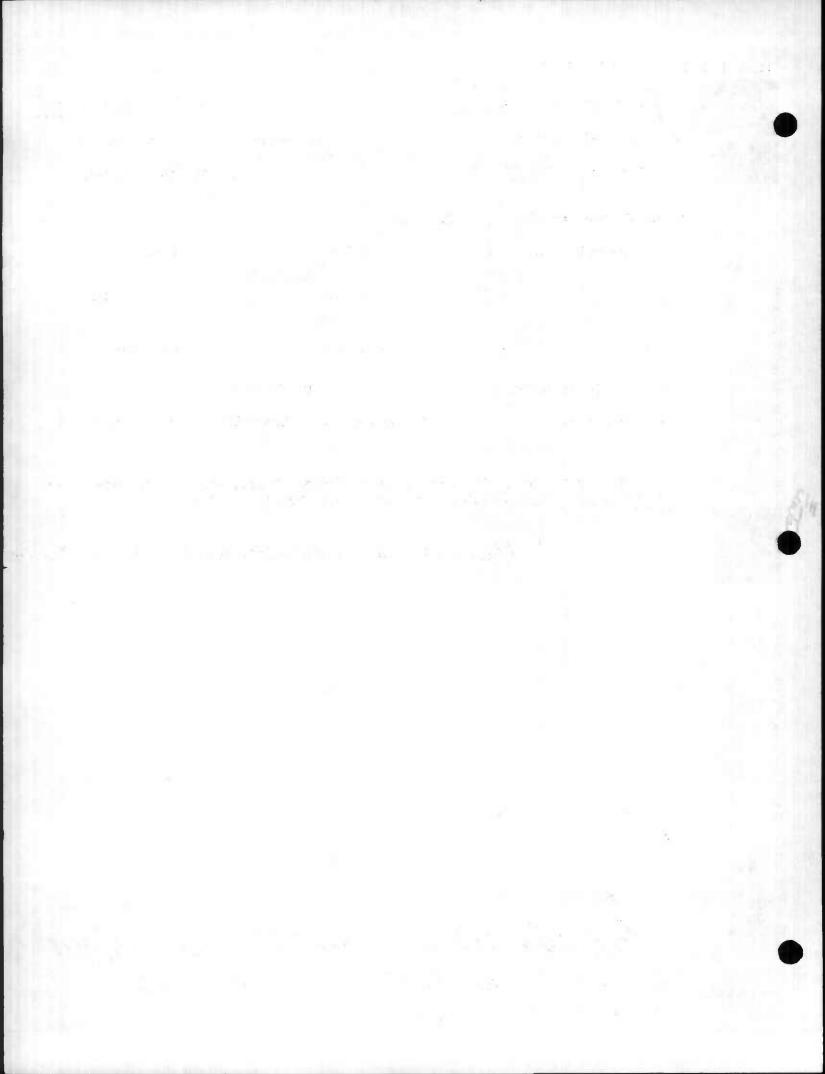
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foreign Country) **Funeral** Deys 1□ M 2√ F 332-24-5806 67 Yrs. Director Aug. 21, 1930 Maryland Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral', or items 23e or 28e-f shore examined at Director 1 ☐ Yes 2/☑ No Maryland Anne Arundel Shady Side 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6285 Shadyside Road 20764 U.S.A. 230 death Funeral items ? 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 St Widowed 4 □ Divorced Completed The Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be 1 nent of Health end Mental I int: If Item 27 Is marked or George Edward Peniston Iva Murphree 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) David Ross/son 312 Beach Drive, Annapolis, Maryland 21403 or other 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. 4 Donetion 5 ☐ Other (Specify) 21. Signature of Fun rel Service Licansee Ronald S. Wade, ²² Name and Address of Facility Board, 655 W. Baltimore Street Director alle Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between **Physician** /Medical Immediate Ceuse (Finel ADENOCARCINOMA MONTH disease or condition resulting in death) **Examiner** Examiner shysicien and the bunal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai Due to (or as e consequence of): 98 for use Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ director, page 2 should Completed 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? this certificate has been 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To filled in by the funeral 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division After 1 A Neturel
2 Accident 5 Pending investigation efter death. 1 TYes 2 □ No 3 Suicide 6 Could not be determined Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Hospital To the Hospital within 24 hours e Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number D 16354 29d. Date signed (Month, Dey, Year) (Item 23e) (Type, Print)
BESTOATE ANNAP. M 30. Neme and eddress of person who completed cau

State Registrar 31. Dete filed (Month, Dey, Year)

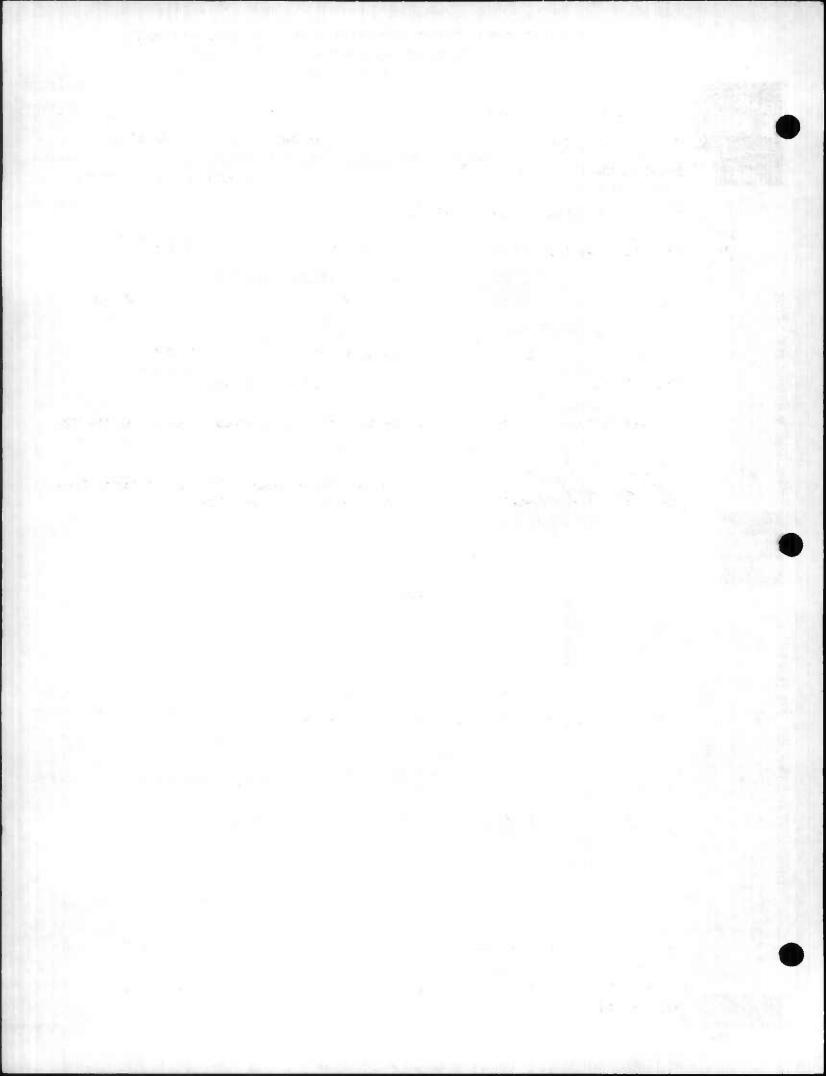
JAN 2 6 1998

32. Rogistrar's Signature



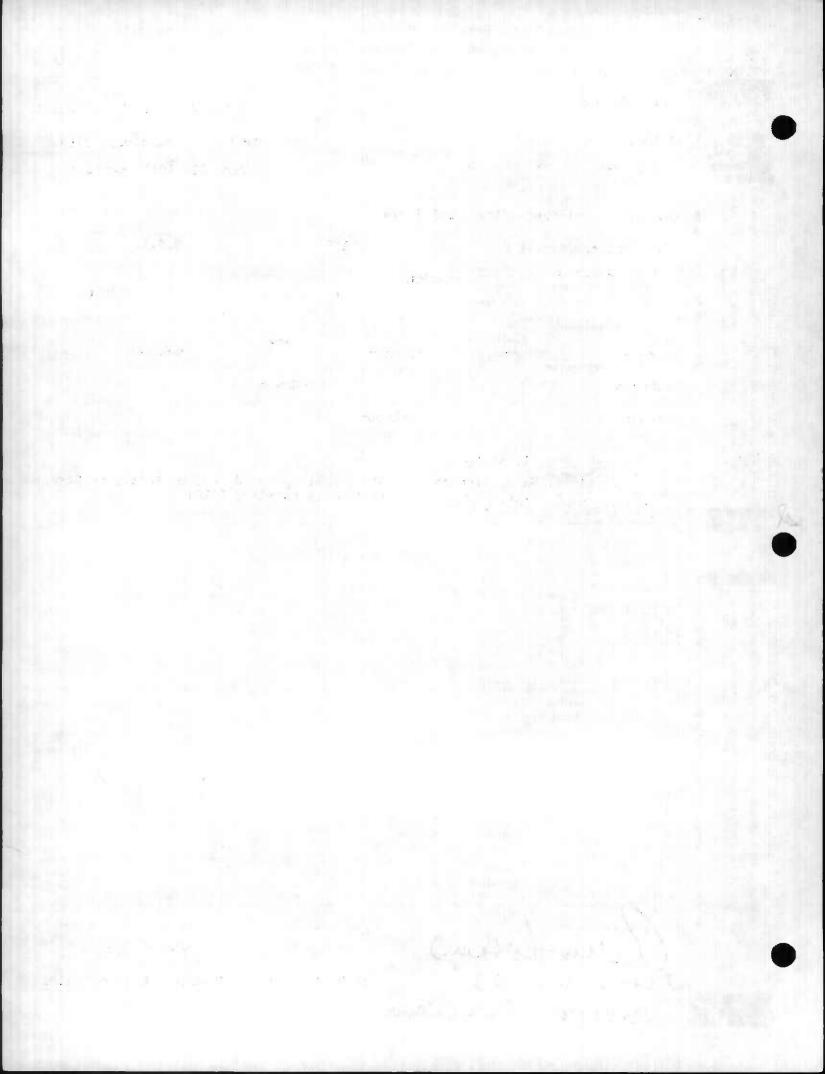
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den etec		15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dec	edent's U	suel Occup	ation during most o	f working	16b. Kind of B	usiness/Industr	у		
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-		Betty Branfmar	n/sister		925	Hali	fax A	venue,	Daytona,	3780				
any injury or other traumatic svent, tra Madical Examiner must be nortified at other. To Be Completed by Funeral Director	2	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special			ece of Disp ametery, cri	position (I emetory (- City or Town, Stete							
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To Be (25. Wes case referred to medical exeminer?						26. Place of	Deeth (Check only	one)				
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tion:	2	7. Menner of Déath 1° ✓ Natural 5 ☐ Pending investigation	28e. Date of Inju (Month, Da	ay Year)	28b. Time Injury	of M	28c. Injur Wor	y et k? Yes 2 ☐ No		how injury occur	red			
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	> gaginal P melle m.o D41410								January 20th 1998.					
	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) JCGINDER PMEHTA NORTHNEST HOSPITAL CENTER RANDAUSTONN MO 21133 Tele filed (Month Par Year) Julie Business Panelyses													
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Physician	Jim Scotney					Month	Dey Year RY 8, 1998 9:49P.M.						
/Medical Examiner	4e Facility Nema (If not institution, give	street and number)			4b. City, Town, or	JANUARY Location of Daat							
Examiner	UNION MEMORIAL HOS	SPITAL			BALTIM	ORE	Balti	more City					
Funeral	5. Social Sacurity Number 6. Sa	7	Mon	ndar 1 Year ths Days	If Under 24 Hrs Hours Min	s. 8. Date of Bir	th by, Year)	Birthplace (State or Fon Country)					
Director	Usual Residence of Decedent	XM 2□ F 50	Yrs.			June 22	2, 1947	unknown					
dand ww	10a. Stata 10b. County	10c. Ci	ty, Town or Location					10d. Insida City Lin					
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death with the Maryland ms 23a or 28s-f show mmust be neithed at neral Director	10e. Street end Number			Zip Coda			10g. Citizen of V U.S.A.	en of What Country?					
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Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other tr page.	21. Signeture of Funeral Service Licensee Ronald S. Wade, Director State Anatomy BoARd, 655 W. Baltimo Baltimore, Maryland 21201												
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Betwee Onset end Decided Section 1. Set IZURE DISORDER resulting in death) Approximate Interval Betwee Onset end Decided Section 2. Set IZURE DISORDER resulting in death)												
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Division o To the Respital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 DCould not be 4 Homicide determined	unknown 28e. Place of Injury - At h building, atc. (Speci	unknown Mome, farm, street, ta		Yas 2 XXNo	City or To	(Straet end Numb wn, Stete)	per or Rural Routa Number,					
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To the Hospital within 24 hours To the Funeral I completely filled Medical Ce		ner: On the basis of examination and mannar stated.											
To the To the comp	29b. Signature and title of certifier	1 0		29c. Licens	se number	29d. Data signed (Month, Day, Year)							
	1 Law	tortem)	O.C	JANUARY 9,1998								
	J. CARON LOCK	omplated causa of death (Ital		1 Peni	n Street	, Baltim	ore, Mai	ryland 21201					
State Registrar	31. Data filed (Month, Day, Year)	32, Registrar's Sign	ature Randoll										

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Data of Death Month George Henry Schlee 19, 1998 Jan 11:20 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death 10720 Marriottsville Road Randallstown Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 1⊠M 2□F Days Yrs 82 213-05-4766 May 9, 1915 Maryland Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Baltimore Randallstown 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 10720 Marriottsville Road 21133 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Marriad 1 ☐ Yas 2 🔀 No Specify: Specify: 3 x Widowed 4 ☐ Divorced WW II White Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Ellicott Machine Co 9 years Pipefitter 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Barbara Schneider Anthony Schneider 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 10428 Old Court Road Granite, MD Ken Schlee (Nephew) 20b. Placa of Disposition (Nama of cematary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Lake View Memorial Park 1/22/98 Sykesville, MD 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. MSs Randallstown, MD 8728 Liberty Road 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) NAL Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona)

Examiner The law requires that the death certificete be executed P.O. Box 68760, ate has been signed by the ette page 2 should be deteched for Records, Division of Vital

by Completed director. Be 2

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours after death a neat of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or thems 23, must if item traumatic event, it a Mentical Experimentary or other traumatic event, its Mentical Experimentary.

permit. Pege Depertment of Important: if eny Injury or once.

Physiclan /Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

with the Maryland

After this certificate Hospital or Attending Physician: s efter death. filled in by the • Funerel completely To the Vithin 2

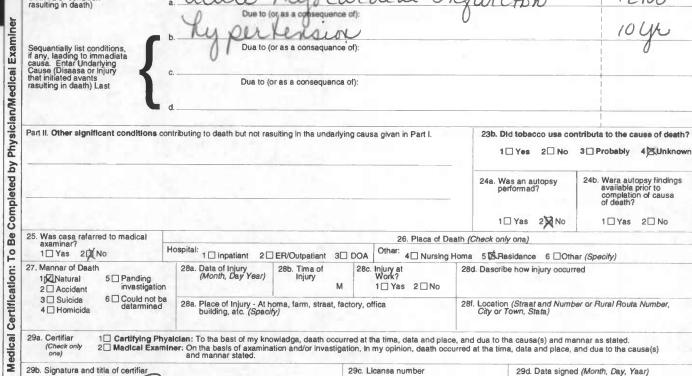
State Registrar

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

Dr. Michael Pearlman

JAN 26 1998

31. Data filed (Month, Day, Yaar)

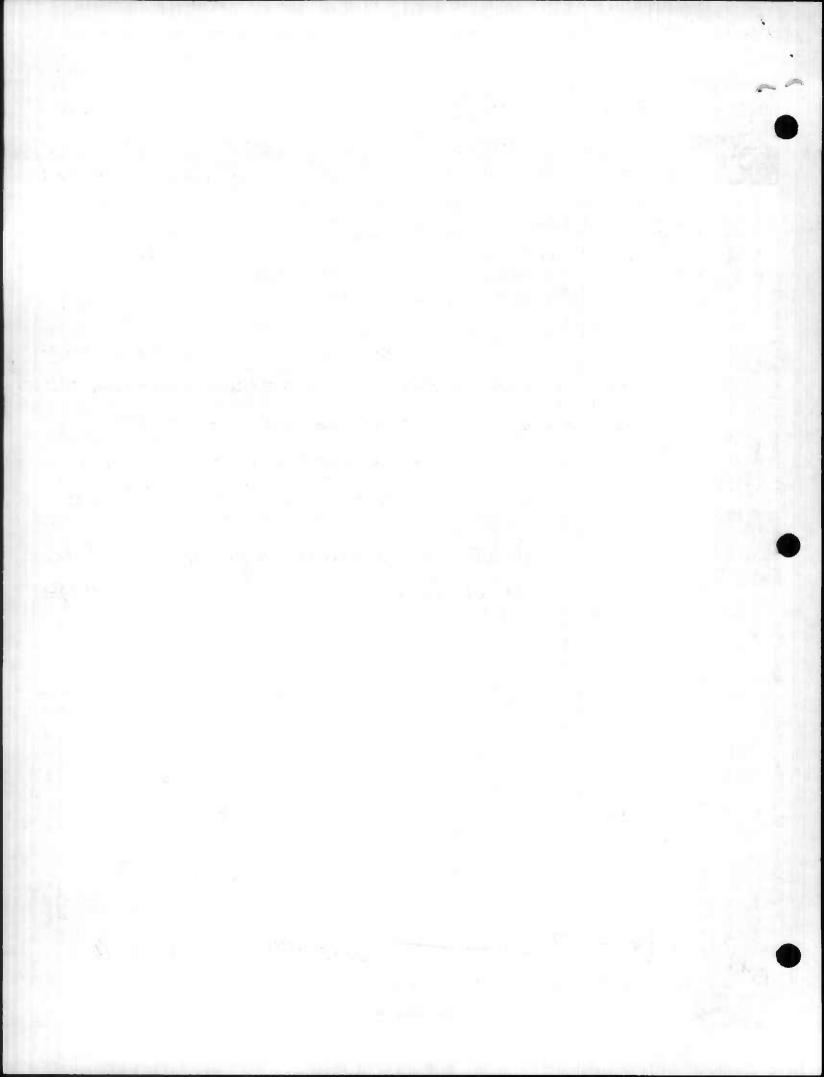


21133

Randallstown, MD

5400 Old Court Road

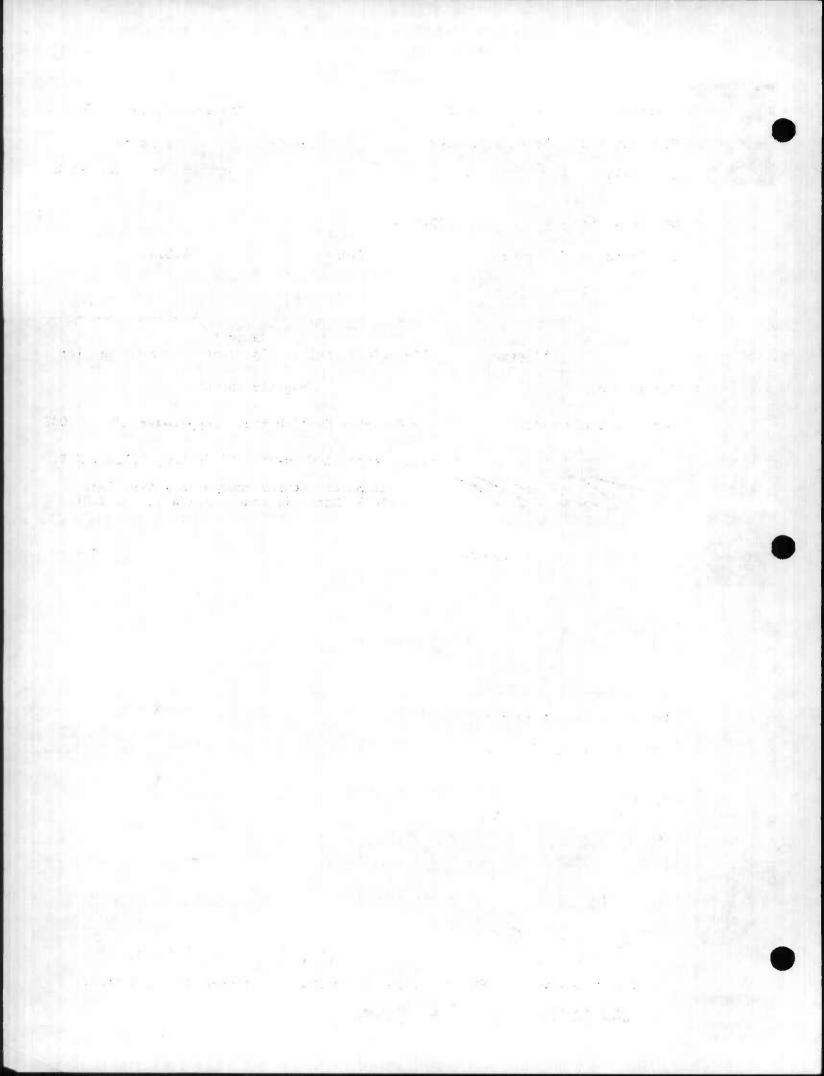
egistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1558

					Certific	ate of	Death		Reg. No.	UI	000			
		1. Decedent's Name (First, Middle, Las	1)					2. Date of Dea	ath	Yaar	3. Time of Death			
Physi /Med	dical	Robert Pete 4a Facility Name (If not institution, give		DLZ			4b. City, Town, or	January Location of Death	Day 7 20, 19 4c. County	98	5:20 PM			
Exam	iner	Franklin Square H		ntor			Rosedale		Balti					
Funera	- L	5. Social Security Number 6. Se		(In yrs. last I		der 1 Year	If Undar 24 Hrs.	8 Date of Birt	h	9. Birthola	ica (State or Fore			
Directo		132-09-5466 Usual Residence of Decedent	XM 2□F 75		Yrs. Mont	hs Days	Hours Min.	Oct. 2	3, 1922	New	York			
/land		10a. State 10b. County		10	10d. insida City Limit									
Men	tor	Maryland Harford		Joppa	atowne						1□ Yas 2⊠N			
th the	irec	10e. Street and Number			10f.	Zip Code			10g. Citizen of W	What Country?				
th wil	a	504 Foster Knoll	Drive			21085			U.S.A.					
BAIKIMORE, MARYIANG 21213-0020 permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28s-f ehow any injury or other traumatic event, in Modical Experimet must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Decadent E Armed Forcas? 1 XYas 2 N If Yes, Give Yaar or Datas:	241-2		ecedant of specify Cubs	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blace Specify.	- America k, Whita, a Wh				
2 hou	Pe	15. Decedent's Edi	ucation	16	Se. Decedent's U	Isual Occu	pation		16b. Kind of Bu					
ZIS Pin 7: In 'n	Be Completed by	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5-	+)	(Give kind of life. DO NO	work done Tuse retire	during most of worded) Ow	mer &						
Manual Ma	E O		+ years		lectrica	al En	gineer/Op	erator	Meinek	e Muf	fler			
nd High	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Surnam	a)				
Via Menid Me	9	George Stolz						n Braun						
2 sh and is m		19a. Informant's Name/Relationship (T					t and Number or Ru							
e, F		Joyce E. Stolz (W	ife)				noll Driv	Date Jop	20c. Location -		21085			
Dallinore, Semit. Pages 1 er Department of Hea mportant: if item 3		1 Burial 2 Cremation 3 X 4 Donation 5 Other (Specify			of Disposition (tery, crematory awn Memo									
permit. Departimporta any infi	SUCE	4 Donation 5 Dother (Specify) Pinelawn Memorial Gardens 1/24/98 Long Islam 21. Signature of Funeral Source Uconson Schimunek Funeral Home of Bel Air, MD. 610 W. MacPhail Road, Bel Air, MD.												
Physiciai		23a. Part1. Enter tha disease, or comp shock, or heart failure. List only o	lications that caused one cause on each lin	the death. D							Approximate Interval Between Onset and Death			
/Medica	1	Immediate Cause (Final disease or condition Sepsis												
Examine		disease or condition Sepsis resulting in death) Due to (or as e consequence of):												
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and -trans	жаш	Sequentially list conditions, if any, leading to immediate												
be ey	a m	Cause (Disease or injury	c											
rificate be executed ag physician and es the bunel-transit	Medicai Examiner	thet initieted events resulting in death) Last	Due to (or as a consequenca of):											
es thet the death centioned by the attendin	Physician/M		d							1				
the deal	sici	Part II. Other significant conditions co	ntributing to death bu	t not resulting	g in the underlying	ng cause g	ivan in Part I.	23b. Did	obacco use cor	tribute to	the cause of dea			
thet the	Phy	Congestive heart	failure					10	Yes 2 No	3 Prob	ably 4 Unknown			
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VITAL INCOLOSSISTANT THE IAW REQUIRES Certificate has been significated, page 2 should be	Be Completed	Coronary artery	disease						an autopsy med?	avai con	re autopsy finding ilable prior to aplation of causa eath?			
The law rate has b page 2 s	du							10	ras 2 No		Yes 2□ No			
vital indicate certificate rector, pag	Ö	25. Was case referred to medical					26 Place of Do	ath (Check only o		10	165 20 140			
Physician: this certific ral director,	To B	examiner?	Hospital:	nt 2□ FB/6	Outpatient 3□	DOA O	har:	tome 5 ☐ Resid		er (Specify)			
Attending Physer death. Tector: After this by the funeral di		27. Manner of Deeth 1 Natural 5 Pending	28a. Dete of Injur (Month, Day		D. Time of Injury	28c. inju			now injury occurr					
	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At home, (Specify)				28f. Location (3 City or Tox	Street and Numb vn, State)	er or Rural	Routa Number,			
To the Mospital or winin 24 hours after Company of Company of the	Belga	29a. Certifier Certifying Phy	sician: To the best of	examination a	ge, deeth occur and/or investiga	red at the t	ime, dete and plece oplnion, death occu	e, and due to the arred et the time,	cause(s) end me dete end place, a	nner as sta and due to	ated. the cause(s)			
\$ \$ \$ E	NB NB	29b. Signature and title of certiller	and manner stal	eU.		29c. Licer	sa number		29d, Date signer	(Month, C	Day, Year)			
F 8	1	1/2	//			DVI	2021-	29d. Date signed (Month, Day, Year)						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
10		DR Mohammad Rahna				uare	Drive Bal	timore 1	Maryland	2123	37			
. S Regis	tate	31. Date filed (Month, Day, Year)	32 Faculta	Sandano Sandana	- Handell									

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 20b per FH G-755 1/26/98 dh 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month ottswood 2:03 DM Margaret 1998 Jan 22 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Bayview Medical Center Baltimore n/a If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Yeer) 5. Social Security Number if Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 X Months Deys 71 Yrs. Director 240-36-8926 Aug. 15, 1926 NC Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23e or 28e-f show the Medical Examiner must be notified at Md 1 ☐ Yes 2 7 100 Director **Baltimore** Dunda1k 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 818 Peach Orchard Lane Funeral 21222 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ▼▼ Was Decadent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced B1k Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12th Domestic other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill thent of Health end Mental H lant: if item 27 is marked out Be Willie Harris NAomi Jones 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health er important: if item 27 is eny injury or other trau 111 Avonbeach Rd. Balto, MD 21222
Date of Disposition (Neme of Date 20c. Location - City or Town, Stete Annie Harris/sister Baltimore, 20b. Plecs of Disposition (Neme of cemetery, capmetory, or after plece)
Garrison Forest V.A. Cemetery
Maryland National 20a. Method of Disposition Muriel 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) Laurel, MD Fignature of Funeral Servica Licensee 22. Name end Address of Facility James A. Morton & Sons Funeral Home 100 1701 Laurens St. BAlto., Md 23a. Pert1 the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) thmia Examiner ue to (or es e consequence of): D Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medical Due to (or es e consequenca of): ate hes been signed by the apage 2 should be detached in Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificate of Vital Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After sion 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 6 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner stated. 29a, Certifier 29b. Signeture end little of contillion 29c. License number 29d. Date signed (Month, Dey, Yeer)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person wi JHBMC

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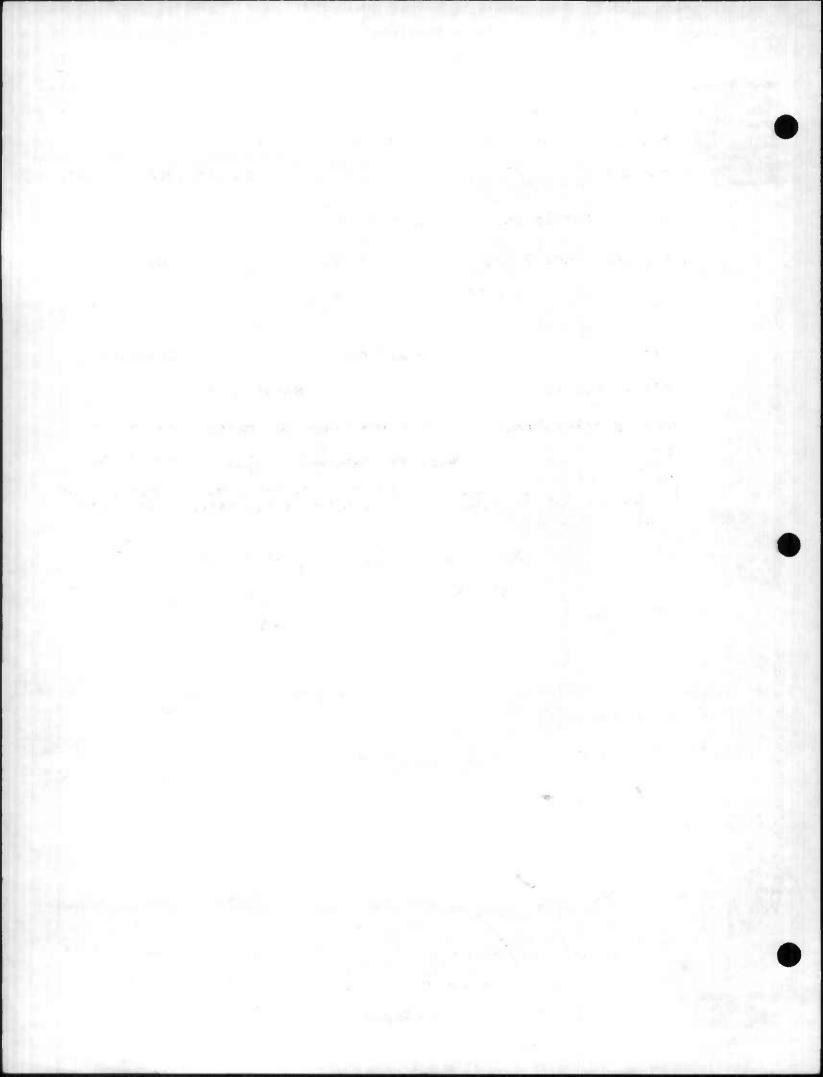
Ase Eastern 32. Registrer's Signeture who Davidson

pleted cause of deeth (Item 23a) (Type, Print) DAVID J · NAIMAN

96710 P-10391

Baltimore MD

Jan22



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Mildred Shagogue 23, 1998 Jan 2:50 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Augsburg Lutheran Home Lochearn Baltimore 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Deys 1□ M 2⊠ F Hours Director Yrs 220-14-4152 93 March 6,1904 Virginia Usuel Residence of Decedent death with the Maryland 10e, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 No Maryland Baltimore Lochearn 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6825 Campfield Road 21207 Funeral U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Dates: 14. Raca - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify. ò 3₺ Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Housewife Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Hugh Rinker Unknown McI1we 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. Marcus Shagogue, Jr. 303 Janet Road Reisterstown, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery Woodlawn , Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. enterio 8728 Liberty Road Randallstown, MD 21133 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** PNEUMONIA /Medical Immediete Ceuse (Final JON disease or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner bunal-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): physician s tha burial P.O. Box 68760. Physician/Medical Due to (or es e consequence of): ettending Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the deteched 23b. Did tobacco use contribute to the cause of death? signed by Dem EnTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. à 8 Be Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Deen page 2 s cartificate hes 1 Yes PENO 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? Medical Certification; 28b. Time of 28d. Describe how injury occurred Attending Naturel 5 Pending investigation daath. 1 TYes 2 No 2 Accident by the ral Director: 3 Suicide 6 Could not be To the Hospita or An within 24 hours after da 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier

Registrar

29b. Signature end title of cartifier

1ASNEEM (31. Date filed (Month, Dey, Year)

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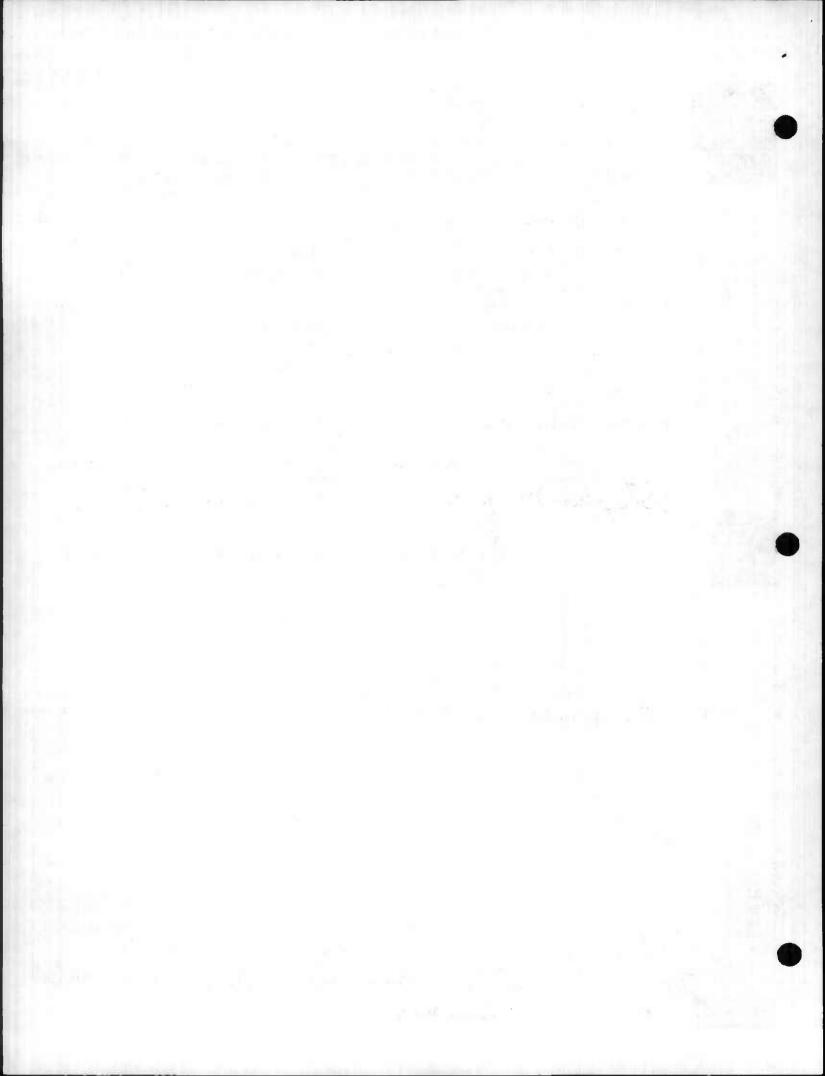
30-Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

PARK

29d. Date signed (Month, Dey, Year)

HEIGHTS AVE, BACK MD 21208



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month -LIAN JANUARY 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Elizabeth's Nursing Home Baltimore If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yeer) 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 1□ M 2 F Months Days 220-24-7426 88 Yrs. June 23,1909 Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2501 Christian Street 21223 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) August Rockel Edith Lillian Ritter 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary S. Johannessen, daughter 3102 Green Way Drive Ellicott City, Maryland21042 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 St Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 1/27/98 Dorsey, Maryland 22. Name end Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Maryl The caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, your cause on each line. Maryland 21227 23a. Part1. Enter the disease, or complete shock, or heart failure. List only on Approximete Interval Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in death) Due to (or es e consequence of) Vusular Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Kruni Due to (or es e consequence of): Pert II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Rent I. 23b. Did tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 1 N 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

physician

Depentment of Important: If it any Injury or o

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23s or 28s-f show Examiner must be notified at

"natural",

Pages 1 and 2 should be filed within 72 ho nent of Heelth and Mental Hygiene. Ant: If item 27 is marked other than "naturury or other traumatic event, Inc. Medical and present, Inc. Medical and present, Inc. Medical and present.

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Baltimore, Maryland 21215-0020

Examiner buriel-transit the 98 signed by the ettending to be deteched for use pege 2 should

or Attending Physician: The law requires that the death certificate be executed

certificate

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Director: Al

within 24 hours of To the Funeral I

Box 68760,

Division of Vital Records, P.O.

Completed by Physician/Medical Be Certification: To B

25. Wes cese referred to medical exeminer? 1 ☐ Yes 2 No 27. Manner of Death

29a. Certifier

(Check only one)

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Dete of Injury (Month, Day Year)

son who completed cause of deeth (Item 23a) (Type, Print)

28b. Time of

28c. Injury et Work? 1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signature end title of certifier

30. Name end address of pr

29c. License number

29d. Date signed (Month, Dey, Year)

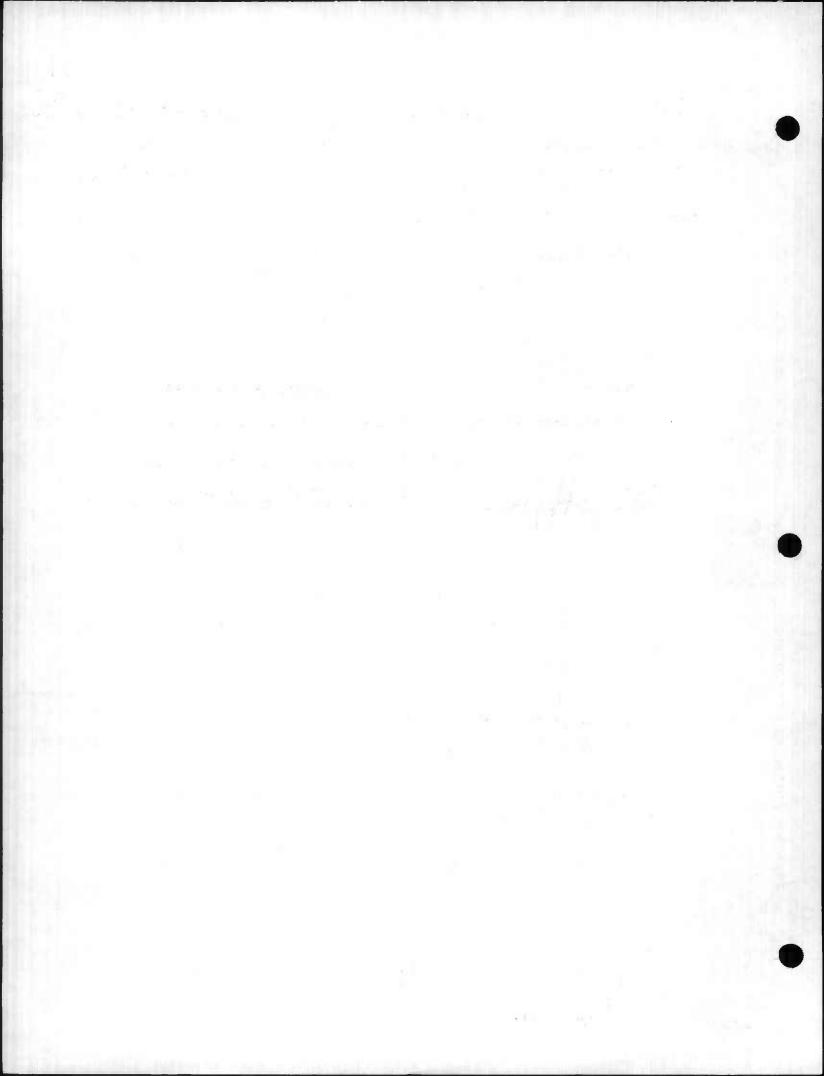
State Registrar

Medical

Denson 31. Date filed (Month. Pay, Year)

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32. Registrer's Signature wha Davidson

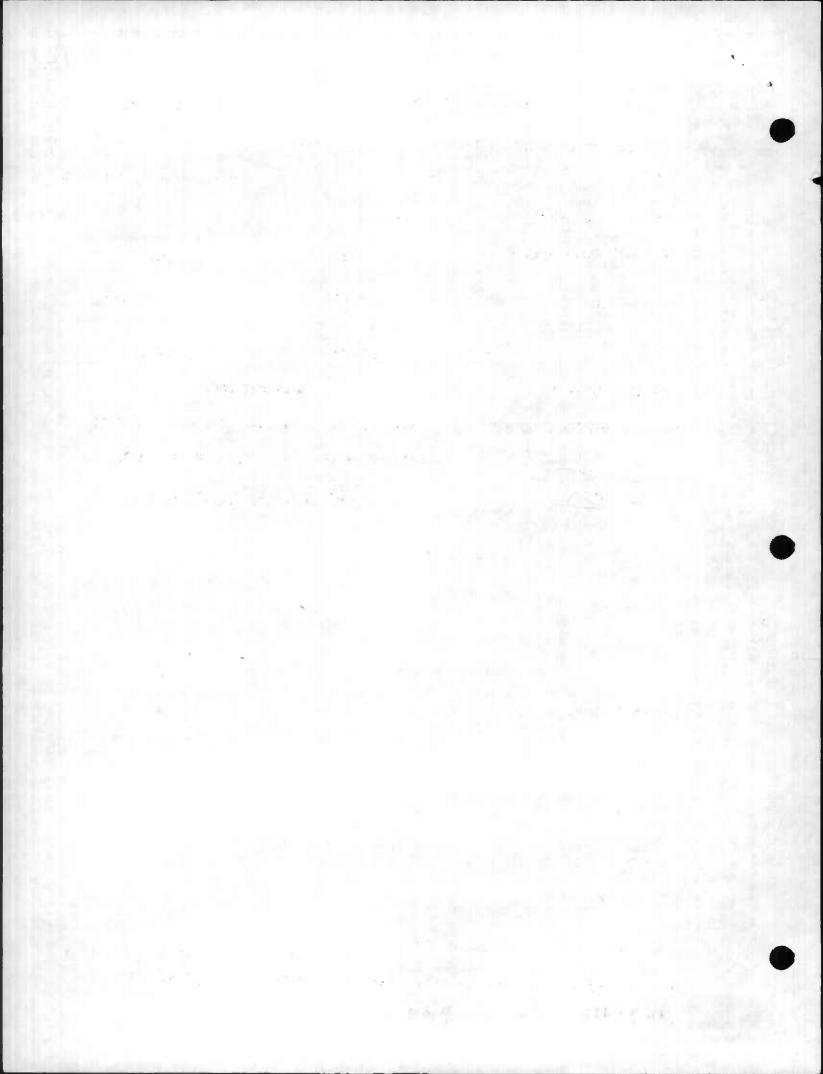


State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 22, 1998 **Physician** SKUROW Rae 1:38 PM Linda /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Rosedale Baltimore Franklin Square Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2X F Months Hours Min. Yrs 42 Director 220624019 March 14,1955 MARYLAND Usual Residence of Decedent with the Maryland r 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 Yes 2 No BALTIMORE Director ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pagas 1 and 2 should be filed within 72 hours effer death with I Department of Health and Mental Hygiane.
Important: If item 27 is marked other than "natural", or items 23a or a say injury or other treumatic event, the Wester Example on once. 8019 EDGEWATER AVENUE 21237 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DISABLE 8 DISABLE 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARGARET NOCAR 2 HAROLD SKUROW 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8019 EDGEWATER AVENUE ROSEDALE, MD 21237 MARGARET HEETER / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tXXBurlal 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 1/26/98 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Bervice Liberasee 22. Name and Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 3 days /Medical Immediate Ceuse (Final Pneumonia diseese or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events physician and s tha burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): resulting in death) Last attending pl by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 Alcohol Abuse 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy Completed performed? cartificeta hes birector, page 2 s 1 Yes 2 No 1 TYPS 2 No Hospital or Attending Physicien: 24 hours after daath. 25. Was cese referred to medical examiner? funaral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident rector: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direct complately filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner steted. 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number P.M. well January 22, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Stuart Willes MD 9000 Franklin Square Drive Baltimore Maryland 21237

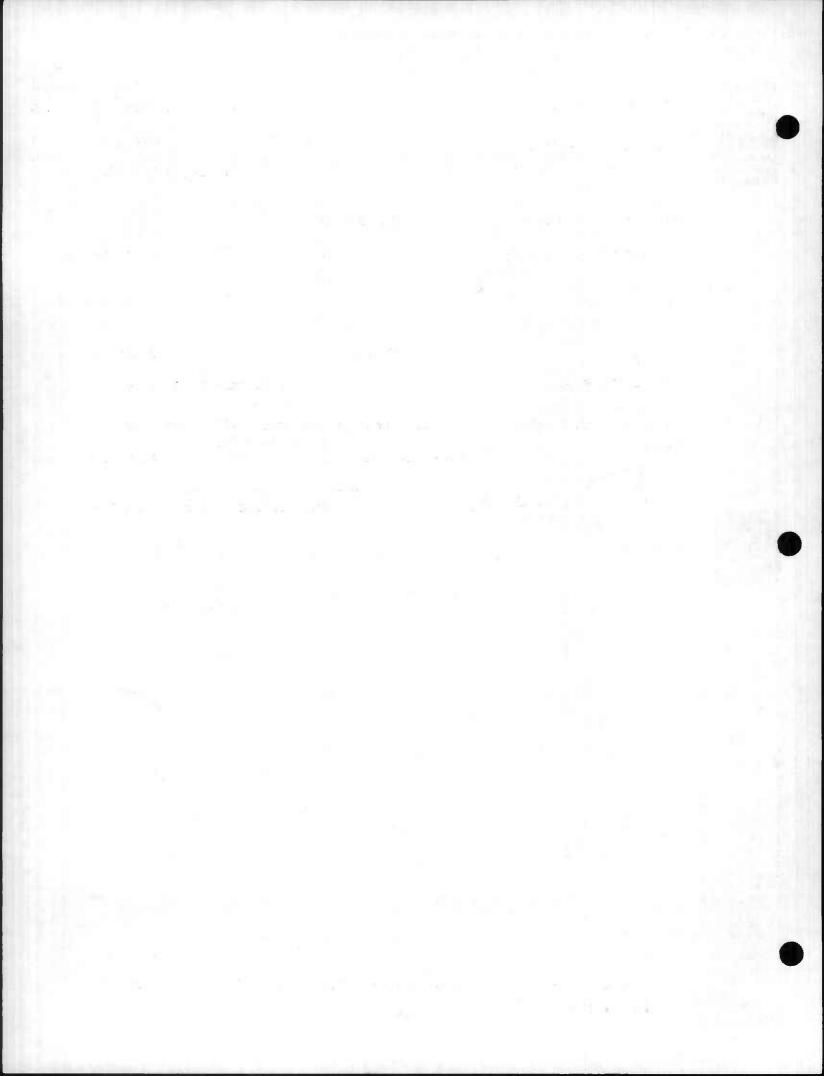
State Registrar 31. Date filed (Month, Day, Year)

Registrer's Signeture



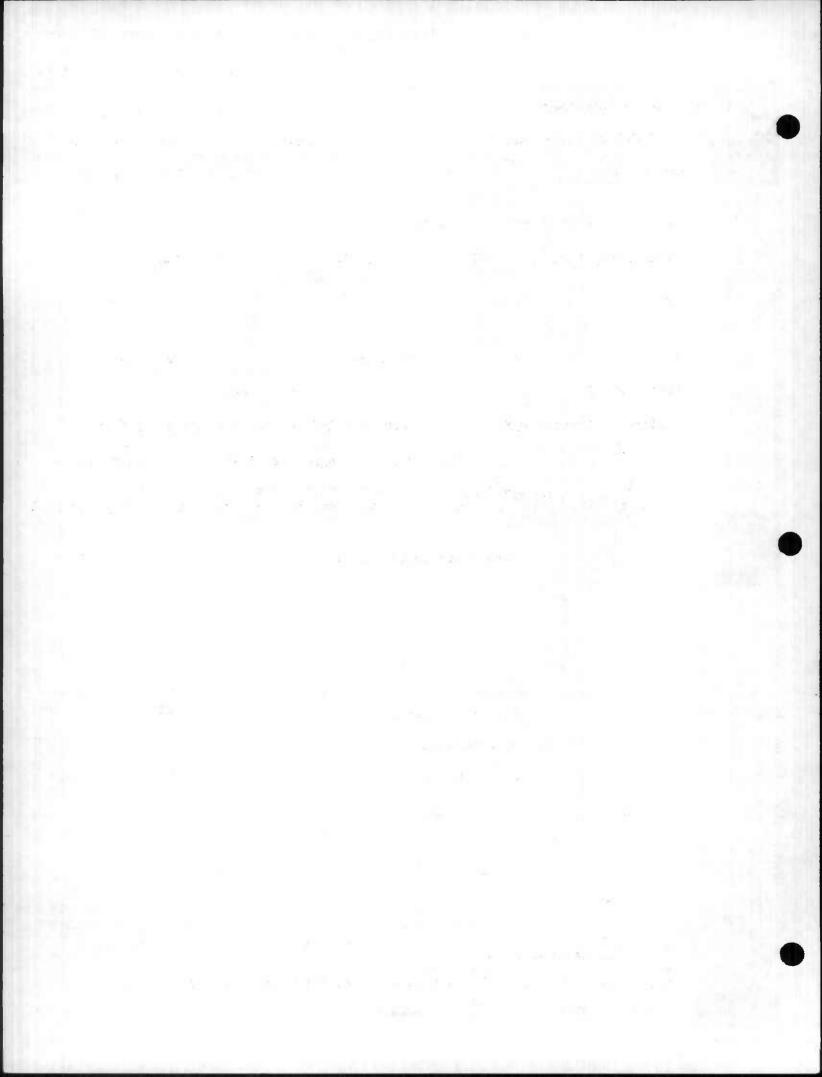
State of Maryland / Department of Health and Mental Hygiene 8 0 | 67

				C	ertificate of	Death		Reg. No.	01013						
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Physic /Med		Irene W. Showal	lter				January	22, 19	98 7:00 A.M						
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he Mary	Director	-	Arundel	(Glen Burni	Le			1□Yes ≱⊡∧						
ter death with the Marylen frems 23a or 28a-f show free must be notified at		10e. Street end Number 1150 Monroe	Circle		10f. Zip Code 2]	1061			izen of Whet Country? United States						
urs el	by Funeral	11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes:	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ♣ No		? (Specify Yes or No Juerto Rican, etc.)	Specify	e - American Indien, kk, White, etc. White							
n 72 hours "natural",	Completed	15. Decedent's E (Specify only highest gr	ducation	16e. De	cedent's Usual Occu	petion	working	16b. Kind of Bu	usiness/Industry						
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should by and Menta or marked umatic ev	2														
Mar d 2 sh th and 7 is m traum		19a. Informent's Name/Relationship					r Rural Route Numbe								
_ 5 8 6 7		P. Jean Clark/DA		b. Pleca of Dis	sposition (Neme of	T	tonsville								
permit. Peges 1 er Department of Hea Important: if item 2 any injury or other once.		20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City of Chemeton State of Disposition (Name of cemetery, cremetory or other plece) 3 September 1998 20c. Location - City of Chemeton State of Disposition (Name of cemetery, cremetory or other plece) 3 September 1998 3 September 1998 3 September 1998 3 September 1998 4 Doubtion 5 September 1998 20c. Location - City of Chemeton State of Disposition (Name of cemetery, cremetory or other plece) 3 September 1998 4 September 1998 4 September 1998 4 September 1998 5 September 1998 6 September 199													
Demit Depart Import any inj once.		21. Signature of Foreign Earvice Licensee 22. Name end Address of Fecility													
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Physician /Medical Examiner	er	shock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)							Oliser end Deelii						
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certificate	BeC	25. Wes case referred to medical				OC Diago of		AA	1 165 2 140						
ystcien: The last certificate he director, pege	ToB	examiner? 1 ☐ Yes 2€XNo	Hospitel: 1 ☐ Inpatient	2 ER/Outpet	ient 3 DOA Ot	hor	Death (Check only only only forme 5 ☐ Resident		os (Cassita)						
Attending Physician: or deeth. ector: After this certific by the funeral director,		27. Manner of Deeth 12⊡Naturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey Year	28b. Time	of 28c. Inju			now injury occurr							
To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined		At home, ferm, ecify)				ocation (Street and Number or Rural Route Number, Sity or Town, Stete)							
To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edicai C	(Check only 2 Medical Exam	ysicien: To the best of my niner: On the basis of exem	knowledge, de inetion end/or	eth occurred et the ti Investigetion, in my	ime, dete end pi	leca, end due to the occurred et the time,	ceuse(s) end ma date end placa, e	nner es steted. and due to the ceuse(s)						
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UA;		18000		6	DY	1491	٥.	Januar	y 23, 1998						
0,4		30. Name end eddress of person who Dr. Gurmett Saw				en Burn	ie. MD 21		ite 202						
Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Si	-		CI. DULII									
Registr	- 1	JAN 28 1998	guila Davido	n-Andel	2										



State of Maryland / Department of Health and Mental Hygiene 98 0 1671

						Certific	cate of	Death		Reg. No.	90 1	110	14	
Physician		1. Decedent's Name (First, Middle,		**					2. Dete of De Month					
/Medical	_	Helen F. Struth	ers						Januar		1998	9:	40 a.m	
Examiner		4e. Fecility Neme (If not institution,		-				4b. City, Town, or	Location of Deet		County of Deet			
		7700 Cherry Lan				44.84	-11	Laurel			ince G			
Funeral Director		132-24-3047	Sex 1□M 2⊠F	7. Age (In yr.			nder 1 Year oths Days	If Under 24 Hrs Hours Min		th ly, Year) 1907	9. Birti Co Sco	hpiece (Si untry) tlan	tete or Foreigr d	
*	-	Usual Residence of Decedent 10e. Stete 10b. County		10c. C	ity Town	or Location						10d Inel	de City Llmlts	
r show			ce George Laurel										Yes 2 No	
28a-f	3	10e. Street and Number	ce Georg	ge L	aure		. Zip Code		10g. Citizen of Whet Country?					
Die Die		7700 Cherry Lan	A - A	#211								unity :		
r items 23s or 28s-f sincer want be notified	5	11. Maritel Status	12. Was Dec	edent Ever in	U,S.		20707 ecedent of I	Hispenic Origin? (Sen, Mexicen, Puer	Specify Yes or No	USA 1	I. Race - Ame	rican indir	an,	
by K	-	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F 1 Yes If Yes, G Year or I	2. No ive			specify Cub		to Rican, etc.)	Black, White, etc. Specify: White				
nt, the Medical Exi Completed by	1	15. Decedent's	Education	ucation 16a. Decedent's Usuel (Give kind of work						16b. Kind	d of Business/	Industry		
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Con the		12	Ø		I	lomema	ker			Own	Home_			
Be ver	2	17. Fether's Name (First, Middle, Le	st)					18. Mother's Ne	me (First, Middle,	Maiden S	'u <i>rna</i> me)			
To affe	2	Robert Flint						Sarah	McConnel	1				
200		19e. Informent's Name/Reletionship			19b.	Mailing Add	iress (Street	end Number or A	ural Route Numb	er, City or	Town, State, 2	(ip Code)		
r other trau		William A. Stru	thers/So					46, Glen	n Dale,					
e de	1	20e. Method of Disposition 1 Deuriai 2 Cremetion 3	□Removel from		Plece of cemetery	Disposition r, crematory	(Name of or other pla	се)	Dete	20c. Loca	ation - City or	Fown, Sta	te	
any injury or o		4 □ Donetion 5 □ Other (Spe		В	altin	nore W	lashin	gton Cr.	1/26	Lau	rel, M	aryl.	and	
any in		21. Signeture of Funeral Service Lic	ensed					ess of Fecility						
5.8		Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20 Approximate Interval fellure. List only one cause on each line. Approximate Interval Between												
edical miner	immediate Couse Final disease or condition resulting in death) e. Metastatic Colon Cancer 1 Year Due to (or es e consequence of):													
urial-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury												
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atached for use			0.											
ysic	F	Pert II. Other eignificant conditions	contributing to d	eath but not re	sulting In	the underfyi	ing cause gi	ven in Part I.	23b. Dld	tobacco u	se contribute	to the ca	uee of death?	
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2 should			Нур	pertens	ion		97			en eutops rmed?	' E	eveileble p	ppsy findings prior to n of cause	
Com			Kid	lney St	ones				10	Yes 2X	ŠNo :	1 🗆 Yes	2 No	
rector, pag		25. Was case referred to medical examiner?	Hospitel:				0.1	hor	eth (Check only o					
ai dire		1 ☐ Yes 2 No	10	Inpatient 2[J DOA		Home 57 Resi			cify)		
Medical Certification: To Be (27. Manner of Deeth 1 Noturel 5 Pending 2 Accident Investiget	ion	of Injury oth, Day Year)	28b. Ti	me of jury M	28c. Inju Wo 1	ry et rk? ∣Yes 2 □ No	28d. Describe	how injury	occurred			
ed in by		3 ☐ Suicide 6 ☐ Could not determine	289. Pieci	of Injury - At I ing, etc. (Spec	nome, farr ify)	n, street, fa	ctory, office		28f. Location (City or To		Number or Ru	ral Route	Number,	
pletely fill edical		29a. Certifier (Check only one) 2 Medical Ex	me, dete end ptace opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) e date end p	nd menner es blace, end due	steted. to the ce	use(s)						
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1	- Calin							D22755 1 26 98						
5	3	30. Neme end eddress of person wh Christine de L					Road,	#260, La	urel, Ma	rylar	nd 2070	7		
State	3	31. Dete filed (Month, Day, Year)	4.1	legistror's Sigr	ature	£.00_								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dev **Physician** Joan R. Shields Month Year January 13 1998 1:35p.m. /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner University of Maryland Shock Trauma Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1□ M 2□ F 579-52-0258 Director 57 Sept. 24 1940 Wash. DC Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Exerciper must be notified at 10d. Inside City Limits Md. Anne Arundel Laurel Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 3387 Style Avenue 20724 Funeral USA 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 "natural", or Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced X nd 2 should be filed within 72 hour alth end Mental Hygiene. 27 Is merked other than "natural r traumatic event, Ira Maddal E. Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3+ Secretary Food & Drug Admin. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 1 end 2 should be f Health end Mental I Christopher Columbus Burton Nancy Day 19a. Informent's Neme/Relationship (Type, Print) 19b. Malting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Depertment of Health el Important: If item 27 is any injury or other trau Claudette Shields/Daughter 3387 Style Ave. Laurel Md. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Wash. Cr. 1/16/98 Laurel Maryland 21. Signature of Furneral Service Licenses 22. Name end Address of Fecility 7601 Sandy Spring Rd. Fleck Funeral Home Laurel, Md 20707 23a. Part. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock or read failure. List only one ceuse on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediete Cense (Final disease or condition resulting in deeth) Examiner consequence of) Examiner ician end burief-transit or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in deeth) Lest Due to (or es e consequence of) physician s the buriel Box 68760. Physician/Medical 98 esn P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? should Completed page 2 s 1 Yes ZI No 1 ☐ Yes 2 No certificate Division of Vital funeral director, Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Yes 2□ No Hospitel: 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Deeth Date of injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturei 5 Pending efter death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 Homicide pelli 24 hours Hospitai Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner state. edicai 29a, Certifier (Check only one) within 2 To the ş 29b. Signature and Mb of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 0

January 13, 1998

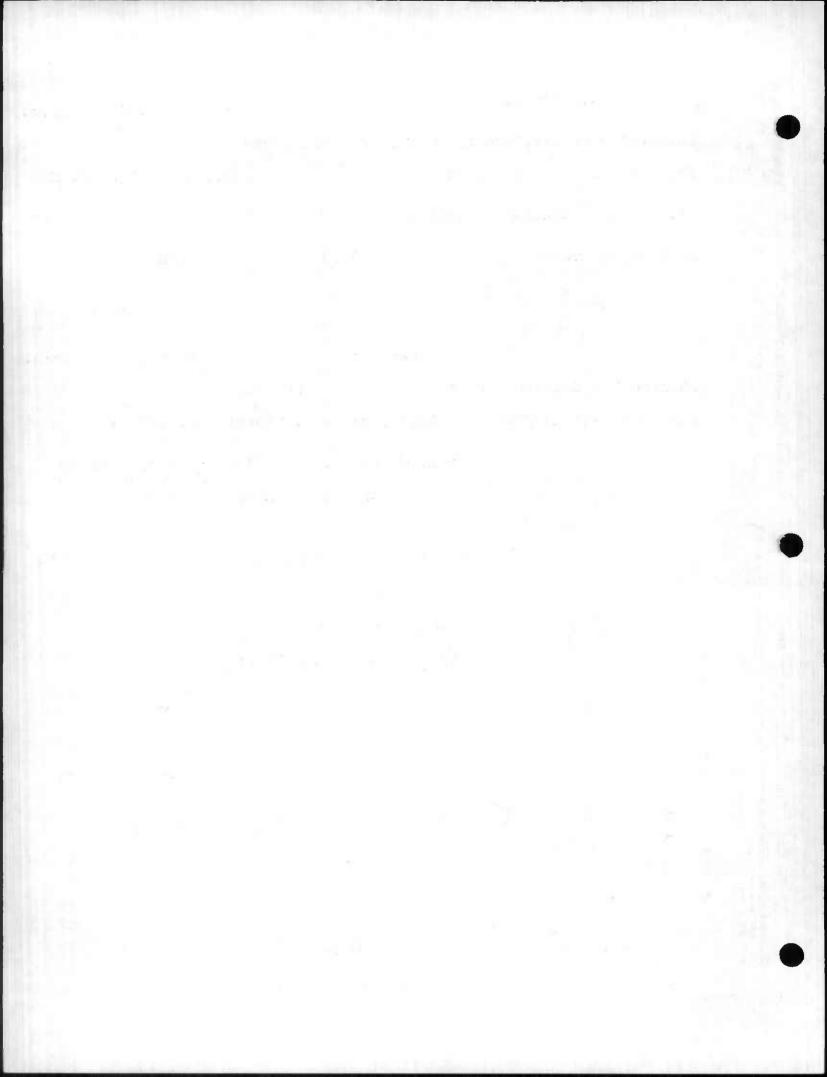
Registrar

R. Adams Shock Trauma Center Baltimore, MD 31. Dete filed (Month, Day, Yeer) JAN 26 1998 was semesor

30. Name and eddress of person who completed ceuse of death (item 23e) (Type, Print)

Charles Wiles, III, MD

N



State of Maryland / Department of Health and Mental Hygiene

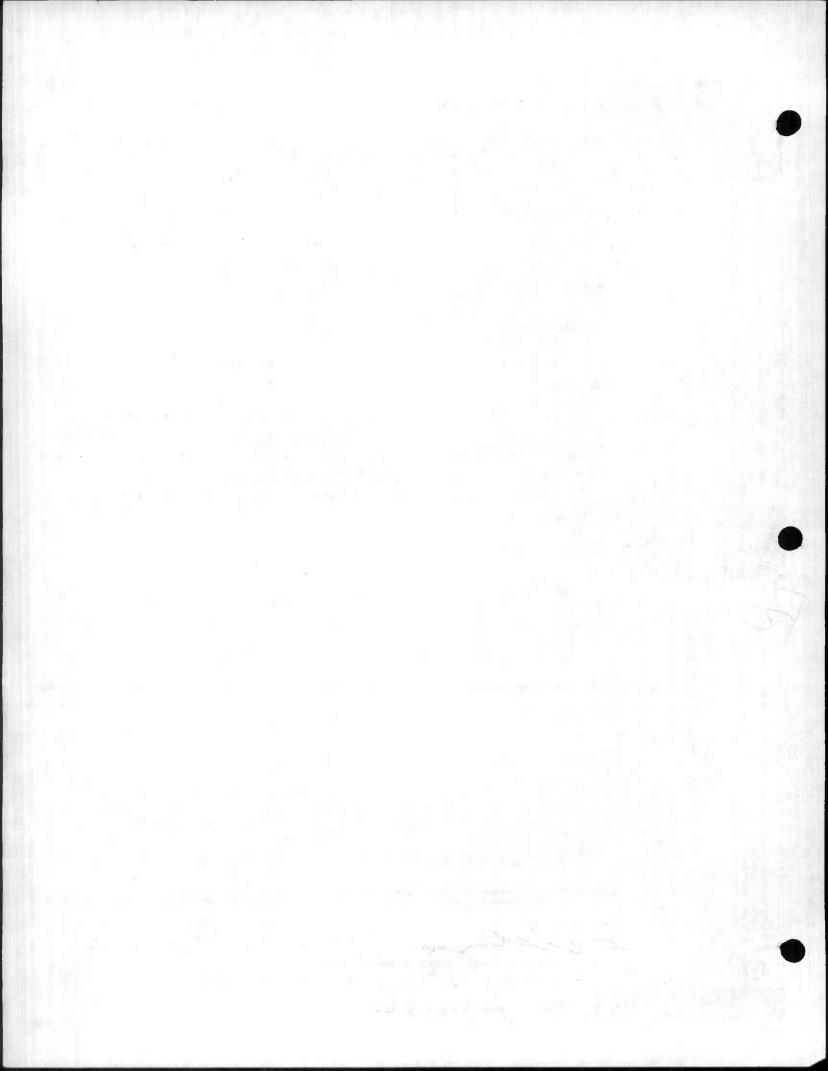
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Funeral		Social Security Number 6		Age (In yrs. lest t	birthdey)	If Under 1 Ye Months Da	ar If Undar	Min. 8. De	ete of Birth Ionth, Dey,		-	ieca (Steta or Foreig	
Director		476-98-1722	ty∏M 2□F	86	WONTE	ys Hours	Aug	ust 1	6,1911	Ind	ia		
p .		Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location											
show	-	Toa. State			11	0d. Inside City Limits							
Ba-f	cto	MD Montgo	mery	Silv	er Sp	oring						1 X Yes 2 □ No	
or 2	Director	10e. Street end Number				10f. Zip Cod	е		10	0g. Citizen of 1	Whet Coun	itry?	
72 hours after death with the Maryland Institute!; or items 23a or 28a-f show ideal Examiner must be notified at	-e	13234 Osterport				2090				India			
er de	Funeral	11. Maritei Status	12. Was Deceder Armed Force	s?	13. W	Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Bleck, White, etc.							
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her t		12 17. Fether's Nama (First, Middle, La	4		Accou	intant	40.14.11	. d. bl /F)			untin	ıg	
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Mar Mar marks	2	Kashi Ram Sahni	18					pati Sa					
2 sh and Is m		19e. Informent's Neme/Reletionship	(Type, Print)	19	9b. Meiling	Address (Stre	eet end Numb	er or Rurel Rou	te Number,	City or Town,	Stete, Zip	Code)	
CHNL		Rakesh C. Sahni	/Son	1	3234	Osterp	ort Dr					yland 209	
t of of		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetlon 3	□Removel from Stell	20b. Plece cemet	of Dispos le <i>ry, cre</i> m	ition (Name of etory or other)	olace)	Dat	Θ 2	20c. Location -	City or To	wn, Stete	
Pages nant of I ant: if Ite ury or of		4 Donetion 5 Other (Spe			more	Washin	gton C	r. 1/2	2 198	Laure1	. Mar	vland	
permit. Pag Department Important: il any injury o		21. Signature of Funarel Service Lice	ensee			Name end Ad	dress of Facili	ity					
8958		1 Lament	1	Vo				1 Home,				1 1 00=	
_		23a. Pert1. Ent/ The disease, or co shock, or least failure. List on	mplications thet ceus	ed the death. Do	not ente	the mode of	ndy Sp	ring Ko	ad, L	aurel,	Mary	land 2070	
Physician		shock, or the failure. List on	ly one cause on eech	line.								Approximate Intervel Between Onset and Death	
/Medical		Immediate Cause (Final	D	110000									
Examiner	и.	disease or condition resulting in deeth)	e	MEUM									
	ē			Due to (or es	e consequ	ence of):					1		
uted	Examiner	b											
certificate be axecuted Iding physician and Ise as the burial-transit	Еха	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying											
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ras that the signed by be detacted.		End Steu	Je Renal	? Dis	eas	Q			1 🗆 Ya	s 2 No	3 ☐ Prob	ably 4 ☐ Unknow	
requiras that the death een signed by tha attar hould be detached for	d by	Find Steve	•					2	4a. Wes en	autoney	24h We	ere eutopsy findings	
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2 5 8	Completed										of o	deeth?	
page	S								1 🗆 Ye	s 2 No	1 🗆	Yes 22 No	
s certificate director, pa	Be	25. Was case referred to madical exeminer?					26. Plec	e of Deeth (Che	ck only one	3)			
0 0	2	1 Yes 2 No	Hospital: 1 ☐ Inpa	tiant 2 ER/C	Outpetient	3 DOA	Other: 4 N	ursing Homa 5	Hasida	nca 6 DOth	er (Specify	()	
ding Pi h. After ti funera		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28e. Date of In (Month, E	jury 28b.	Time of Injury	28c. Ir	jury et Vork?	28d. D	escribe ho	w injury occur	red		
Attending it death. actor: After by the fune	atic	2 ☐ Accident Investigat	on		,,		☐ Yes 2☐	No					
after deat Director: 3 in by the	tific	3 ☐ Suicide 6 ☐ Could not determine	d 286. Piece of I	njury - At home, etc. (Specify)	farm, stree	et, factory, offic	20		cation (Str		er or Rura	Route Number,	
To the nospital or Attending Pri within 2 Hours after death. To the Funeral Director: After the complately filled in by the funeral	Certification:	The state of the s	Sulding,	etc. (Specify)					ty or Town,	, 01010)			
Hospital 24 hours : Funeral ataly filled		29a. Certifier 1 Certifying F	hysicien: To the bes	st of my knowledg	ge, deeth o	occurred et the	time, dete en	nd plece, end du	e to the ce	use(s) end me	enner es st	eted.	
n 24 n Fu ne Fu	edical	(Check only 2 Medical Expone)	eminer: On the basis end menner:	of examinetion e	nd/or inve	stigation, in m	y opinion, dee	eth occurred et t	he time, de	ete end plece,	and due to	the ceuse(s)	
To the Ho within 24 To the Fu complately	29b. Signature end the of certifier 29c. License number									d. Data signe	d (Month, I	Day, Year)	
11			du the			D	3391	42		12	98		
DIA		30 Name and address of pares.	o completed course of	dooth (team 00-	\ (Turne D					1 .1			
5		30. Name end eddress of person where PROMOD Du	CCN LA	72	52 6	3 Hav	D/WK	Parkus	TOW	Green	bell-	- MD 201	
		31. Dete filed /Month Day Veer!	32 00	draw Singative	A	(~ 1							
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DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygienes

					Certific		Death		Reg. No.	U	16//		
Physic	ian	1. Decedent's Name (First, Middle, L.						2. Date of Dea Month	ath Day	Year	3. Time of Death		
/Med		Carl Edward J	oseph Swar	nlund				_	10, 19	98	3:35 P.M		
Exami		4a. Facility Name (If not institution, gi	ve street and number,)			4b. City, Town, or L	ocation of Death	4c. Count	y of Death			
		Doctors' Communi	ty Hospita	al			Lanham		Princ	e Geo	orge's		
_c Funeral		5. Social Security Number 6.		ge (In yrs. last b	oirthday) If Un Mont	der 1 Year		8. Date of Birt (Month, Day			place (State or Foreign htry)		
Director		079 16 3178 Usual Residence of Decedent	DEM 2□F	78	Yrs.	hs Days	Hours Min.	Aug. 2	7,1919	New	York		
ylan		10a. State 10b. County		10c. City, To	wn or Location					1	Od. Inside City Limits		
e Mar	ctor	Maryland Prince	George's	Bowi	е						1 XXes 2 □ No		
and ZIZIS-UUZU be filled within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Mudical Examinat must be notified at	ai Director	10e. Street and Number 4015 Wakefield I	ane		10f.	Zip Code	20715		10g. Citizen of United				
dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,S.	13. Was De	cedent of 1	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ			
urs after	by	1 ☐ Never Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Ves 2 Il Yas, Giva Year or Dates:			s 2 No		Hicen, etc.)	Specify:				
nd I should be filed within 72 hours aff the and Mental Hygiene. It is marked other than "natural", or treumetic event, the Moural Exam.	Completed	15. Decedent's E (Specify only highest gr	ducation	166	a. Decedent's U	Isual Occup	pation	100	16b. Kind of E	Business/In	dustry		
within ene.	npie	Elemantary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	Tuse retire	during most of work d)	ang					
should be filed within the Mental Hygiene. marked other than imatic event, the Mental Hygiene.	Son	12			Sales				Auto	motiv	7e		
of the contract of the contrac	Be	17. Father's Name (First, Middle, Last	")				18. Mother's Nam	e (First, Middle,	Maiden Suma	me)			
2 should be f and Mental H is marked of	2	Harry E. Swanlur	nd				Elin St	ephanss	on				
sho sho	1	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addr	ess (Streat	and Number or Rur	al Route Numbe	r, City or Town	, State, Zip	Code)		
		Carrie E. Swanlı	and Wife	e	4015 Wa	kefie	1d Lane B	owie Ma	ryland	20715	5		
2 80 = 8		20a. Method of Disposition 123 Burial 2 ☐ Cremation 3 ☐	- City or To										
emit. Pa epartmen reportant: ny injury fice.		4 Donation 5 Other (Special		Mary1			Cemetery			ltenham Maryland			
permit. Departrimports any inju		21. Signature of Funeral Service Lice	200 Z	i			Evans Fur apolis Rd.				715		
Physician		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	dications that cause one cause on each li	d the death. Do	not enter the m	node of dyl	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Batween Onset and Death		
/Medical Examiner		Immediate Cause (Final disease or condition Pneumonia											
LAdinate	U	rasulting In death)		Dua to (or as a	a consequence	of):							
2 4	lue						3 months						
The man	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Causa (Disaase or injury that Initiated events	b. Lung Ca	Due to (or as a					2 monens				
ifficate of physical as the burn	edical	Causa (Disaase or injury that Initiated events resulting in death) Last	c	Due to (or as a	of):								
the death certification by the attending packed for use as	Physician/M		d										
deat death ad for	sicis	Part II. Other significant conditions of	contributing to death b	ut not resulting	in the underlyin	a ceuse aiv	ven in Part I.	23b. Did t	obacco uae co	ontribute to	the cause of death		
that the de ned by the a detached i	hy	S/P Surgical Repa									bably 4 Unknow		
es tha igned be de	by	b/i buigical kepa	III ADU AII	eurysm									
requir been s should	Completed							24a. Was a perfor	an autopsy med?	avi	ere autopsy findings ailable prior to mpletion of cause		
The law ate has page 2	E								-E11		death?		
ician: The		25. Was cese referred to medical						1 U Y		11	Yas 2□ No		
Physician: this certific	o Be	examiner?	Hospital:			Oth	26. Placa of Deat						
Phys ral d	. To	27. Manner of Death	112 Inpatie		Outpatient 3 Time of	DOA	4 LI Nuising no	me 5 Resid			y)		
ttanding Phy death. rtor: After this	ion	1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	28c. Injui		zod. Describe n	ow injury occu	rred			
Attanding ir death. actor: After by the fune	cal	2 Accident invastigation 3 Suicide 6 Could not b			М	1	Yes 2 No						
rac rac n by	Certification:	4 Homicide detarmined		ury - At home, fi c. <i>(Specify)</i>	arm, street, fact	tory, office		281. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai C	29a. Certifiar 1 ← Certifying Ph (Check only 2 ← Medical Exar	yaiclen: To the best oniner: On the basis of	of my knowledg	e, death occurre	ed at the tir	me, date and place,	and due to the c	ause(s) and m	anner as st	eted.		
the the	Med	one) 29b. Signature and title-of certifier	and manner sta	ated.		irred at the time, date and place, and due to the cause(s) a atlon, in my opinion, death occurred at the time, date and p							
5 × 6		Section and the country	1,1		29c. License number 29d. Date signed (Month, Day, Year)								
		1000	un	2 mg		D 35820 Jan. 12, 1998					998		
UX		30. Name and address of parson who	completed cause of d	eath (Itam 23a)	(Type, Print)	- 13	it in 16						
R.		Peter Eckberg M.I	. 14300 G	allant	Fox Lan	e #11	O Bowie M	d. 2071	5				
Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature									
Registr	ar	JAN 26 199	18 Juna	Davidson	-gandelle								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Yeer Yeer 2 35PN UCIL 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 9 BN- HOSP. COUNT Westminster Carroll ARROLL If Under 1 Year Months Deys 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Months Hours 10 M X0 F Bennettsville 88 217-16-6448 Dec. 14, 1909 S.C. Usuel Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City. Town or Location 1 Type 2 No Baltimore Md. Reisterstown 10e. Street and Number 10f Zip Code 10g. Citizen of Whet Country? 21136 **USA** 308 Main Street 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Yeer or Detes: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Retail 11 th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ralph S. Lewis Fannie E. Willis 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. Eugene A. Shaw 2520 Foster Ave. (Son) Baltimore, Md. 21224-3745 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Locetion - City or Town. State 1 Deurial 2 Cremation 3 Removel from State Lake View Memorial 1/26/98 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Synature of Funeral Service Licenses 22. Neme end Address of Fecility 11824 Reisterstown Rd. ELINE FUNERAL HOME Reisterstown, Md. 21136 cone 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth ediate Cause (Final 3 days disease or condition resulting in death) Sepsis Due to (or es e consequ year 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 TYPS 2 NO 1 Ves 2 No

Physician /Medical

signed by t

s need should

ate has bage 2 s

certificate Physician:

this

or Attending

death.

To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b

After thi funeral

Director: A

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if then 27 is merked oths any injury or other traumatic event other.

Physician

/Medical

Examiner

Funeral

Director

thems 23s or 28a-f st iner must be notified

"natural", or them edical Examiner,

the Medical

Baltimore, Maryland 21215-0020

filled within

Director

Funeral

Aq

Completed

Be

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Physician/Medical Division of Vital Records, P.O. Box 687

p

Completed

Be

10

Certification:

Medical

State

Registrar

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

5 ☐ Pending investigetion 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

26. Plece of Deeth (Check only one)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name engleddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

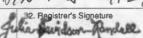
VIBD - C. 1705 ATN MA 412, Malcolm drive Westmuster

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

JAN 26 1998



SHAW, LUCILLE 150-A HOSAIN, SYED S 12/14/1909 F 01/10/98

M

3:30 AM

6. BIRTHPLACE (State or Foreign Country)

PA

2. DATE OF DEATH

7. DATE OF BIRTH (Morth, Day, Year) MARCH 3 1906

12

1998

JANUARY

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should 9c. COUNTY OF DEATH DIRECTOR 613 CAPE MCKINSEY DRIVE SEVERNA PARK ANNE ARUNDEL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? NJ CUMBERLAND BRIDGETON permit. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? be detached for use as the burial-transit 8 MARKLEY DRIVE 08302 USA be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Ricen, atc.)

1 YES 2 X NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced 8-27-42 TO 10-8-45 WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 6 OWENS GLASS QUALITY CONTROL INSPECTOR onca. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Ħ SALVATORI STRANO BE CONCETTA CATALANO notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CATHY DAVIS, DAUGHTER 613 CAPE MCKINSEY DR. SEVERNA PARK, MD 21146 9 Page 6 may 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) ST. MARYS CEMETERY 1/15/9B BRIDGETON, 21. SIGNATURE OF FUNERAL BERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Hilly lours after death. STERLING ASHTON FUNERAL HOME, INC. Marles oy the fun-736 EDMONDSON AVE., BALTIMORE, MD 21228 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, filled in by **Approximata** shock, or heart fallure. List only one cause on each line. 6 Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** n and completely fille to burial, cremation, the th disease or condition SEVERAL STENOSIS ORTIC resulting in death) INSUFFICIENCY traumatic event, YEARS executed with DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): requires that the death certificate be e een signed by the attending physician or Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 50 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any JONE COMPLETION DF CAUSE 1 TYES 2 NO has been s 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO KE UNCERTAIN I OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem certificate h HOSPITAL: OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA • 6 ₺ Other (Specify) DAUGHTER*S RESIDENCE 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c Natural 5 Pending Investigation 84 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Yown, State) 3 Suicide ETED. 6 Could not be 4 Homfolde 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. TO THE FUNERAL OF THE FUNERAL OF THE FUNERAL DE SHEG WITHIN 72 h (Check only one) HOSPITAL IMPORTANT: If 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) mz 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARLES W. 2003 MEDICALPKWY # 32. REMISTRAR'S SIGNATURE Julia Daydyon DHMH-16 Rev 1/89

reb G-755 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

YRS.

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

reb G-/55 SIAIE UF MANTLAND / DEPARTMENT UF DEALIN AN REGISTRAR Item: 26 per Physician 1/26/98ERTIFICATE OF DEATH

STRANO

6. AGE (In yrs. last birthday)

91

BENJAMIN

S. SEX

1 X M 2 1

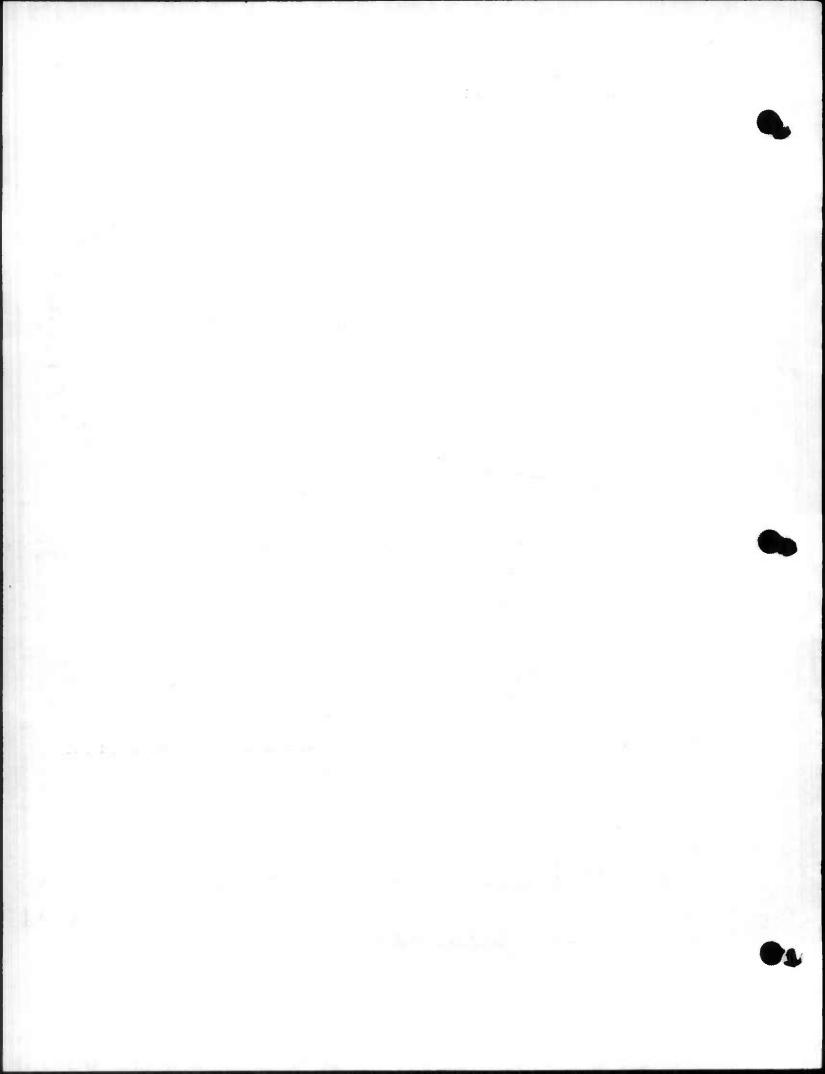
1. DECEDENT'S NAME (First, Middle, Last)

SEBASTIAN

9e. FACILITY NAME (If not institution, give street and number)

4. SOCIAL SECURITY NUMBER

142-09-7359



State of Maryland / Department of Health and Mental Hygiene

3 01680

						Ce	ertificat	e of	Death			Reg. No.				
		1. Decedent's Nar	ne (First, Middle, L	ast)							2. Dete of De	eth		3. Time of Deeth		
Physi /Med		ROBERT	OLIVER S'	TANSBURY	7						Jah	20	1998	414 PM		
Exam		4e. Fecility Neme	(If not institution, gi	ve street end nu	m <i>ber)</i>				4b. City, To	wn, or L	ocation of Deat		ty of Deeth			
1		ST. AGN	ES HOSPI	TAL					BAL	TIMO	DRE		y of Deeth N/A 9. Birthplace (State Country) MARYLAND 10d. Inside C 1 Yes What Country? U.S.A. ce-American Indian, ack, White, etc. fb: WHITE Business/Industry DMERY WARD me) MD 21228 - City or Town, Stete DRE, MD C. Approximate Interval Be Onset end DRE, MD 2. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD C. 1228 Approximate Interval Be Onset end DRE, MD			
Funera	1	5. Sociel Security		Sex	7. Age (In yrs.	lest birthday	/) If Under Months			24 Hrs. Min.	8. Date of Bir (Month, De	th Voor!	9. Birthp	place (State or Foreign		
Directo	r ·	212-01-3	490	1⊠M 2□F	80	Yrs.	MONTHS	Deys	Hours	IVIII.	01/13/	1918				
- P		Usual Residence	_		140.00											
anyla	-		10b. County			ty, Town or I							1	0d. Inside City Limits		
8a-f	cto	MD	BALTII	MORE	Cz	ATONSV	ILLE							1 ☐ Yes 2√ No		
death with tha Maryland rms 23a or 28a-f show rms be notified at	Director	10e. Street and No	ımber				10f. Zip	Code				10g. Citizen o	What Cour	ntry?		
ath v	ra l	1904 RC	LLINGWOOD	D ROAD				21	.228				U.S.A	•		
020 ours efter death with tha Marylan ral', or Herns 23s or 28s-f show Examinat must be notified as	Funeral	11. Maritel Status		Amed Fo		,S. 13	Was Deced If Yes, spec	lent of I- cify Cub	lispenic Ori an, Mexicar	gin? (Sp	ecify Yes or No Rican, etc.)					
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21215-0020 d within 72 hours ef glana. or then "netural, or the Woolcal Exam		3 🗆 Widowed	4 Divorcad	Year or D	ates:											
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21215- d within 72 piana. r than "nat	d L	Etementary/Sec		College (1	I-4or 5+)											
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Baltimore, Maryland; pemit. Pagas 1 and 2 should be filed beperment of Haatih and Mental Hyg Important: If Itam 27 Is marked other any Injury or other traumatic svent,		1X Burtal 2	☐ Cremation 3 [State	emetery, cre	emetory or o	ther ple								
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Ball permi Dapa Impor		21. Signature of 6	Service Lice	nsee		S	22. Name an	d Addre	ss of Facilit SHTON	FUN	ERAL HO	OME, IN	c.			
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Physician		- 0												Onset end Deeth		
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ras ti	b															
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		27. Manner of Dea 1 Naturel	th 5 Pending	28a. Date (of Injury th, Dey Year)	28b. Time Injury	of 2	8c. Injur Wor	y et rk?		28d. Describe	how Injury occu	rred			
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Division or Attending sther death. Director: After d in by the tune	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Coutd not be determined	28e. Pleca	of Injury - At hong, etc. (Specify	ome, farm, s	treet, factory	, office			28f. Location (Street end Nun	ber or Rura	l Route Number,		
0 165	Cer				ig oie (epeen)	,						, 2.2.2,				
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(人)到过	Ž	29b. Signeture end					29c	. Licens	e number			29d. Dete sign	ed (Month,	Dey, Yeer)		
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St Regis	ate trar	JAN 2 6		Julia Da	egistrar's Signa	ndelle										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death SWIECZKOWSKI Month ANTHONY JANUARY 03:04 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Johns Hopkins Bayview Medical Center N/A Baltimore If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 1 XM 2 ☐ F 214-10-0072 75 Aug 10 1922 MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6514 Colgate Ave 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorcad 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dispatcher Trucking 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peter Swieczkowski ANNA SAFFA 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 43 Yorkway Phyllis Hosgood /daughter Baltimore, MD 21222 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Jan Dete 26 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State Holy Rosary Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Baltimore, MD 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Dundalk nthony 7110 Sollers Point Rd 21222 23a. Pert1. Enter the disc e, or complications that caused the deeth. shock, or heert feilule. List only one cause on each line. not enter the mode of dylng, such as cerdiac or respiratory errest, Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? Prostate 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No

Physician /Medical Examiner

use

page 2 should be detac

certificate

this funeral

After

sefter death.

To the Hospital c within 24 hours of To the Funeral D completely filled

in by

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Certification: To

Medical

The law requires thet the deeth certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

permit. Page Depertment of Important: If any Injury or once.

Physician

/Medical

Examiner

10a, State

Director

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the Maryland

Pages 1 end 2 should be filed within 72 hours efter death with the Marylan neat of Health end Mental Hygiene. In this If them 27 is marked other than "natural", or items 23a or 28a-f show into I flem 27 is marked other than "natural", or other traumatic event, its Marilan Examination or other traumatic event, its Marilan Examination or other traumatic event, its Marilan Examination of the page 23a or 28a-f shown and the page 33a or 28a-f show

21215-0020

Baltimore, Maryland

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Physician/Medical Completed by

25. Was case referred to medical

1 | Yes 2 | 1 | Yes

27. Manner of Deeth

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

1 ☐ Yes 2X No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury et Work? 28d. Describe how Injury occurred 1 Yes 2 No

Location (Street end Number or Rurel Route Number, City or Town, Stete)

12 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner steted. 29b. Signeture end title of certifier

5 Pending investigation

6 Could not be

29c. License number

29d. Date signed (Month, Dey, Yeer)

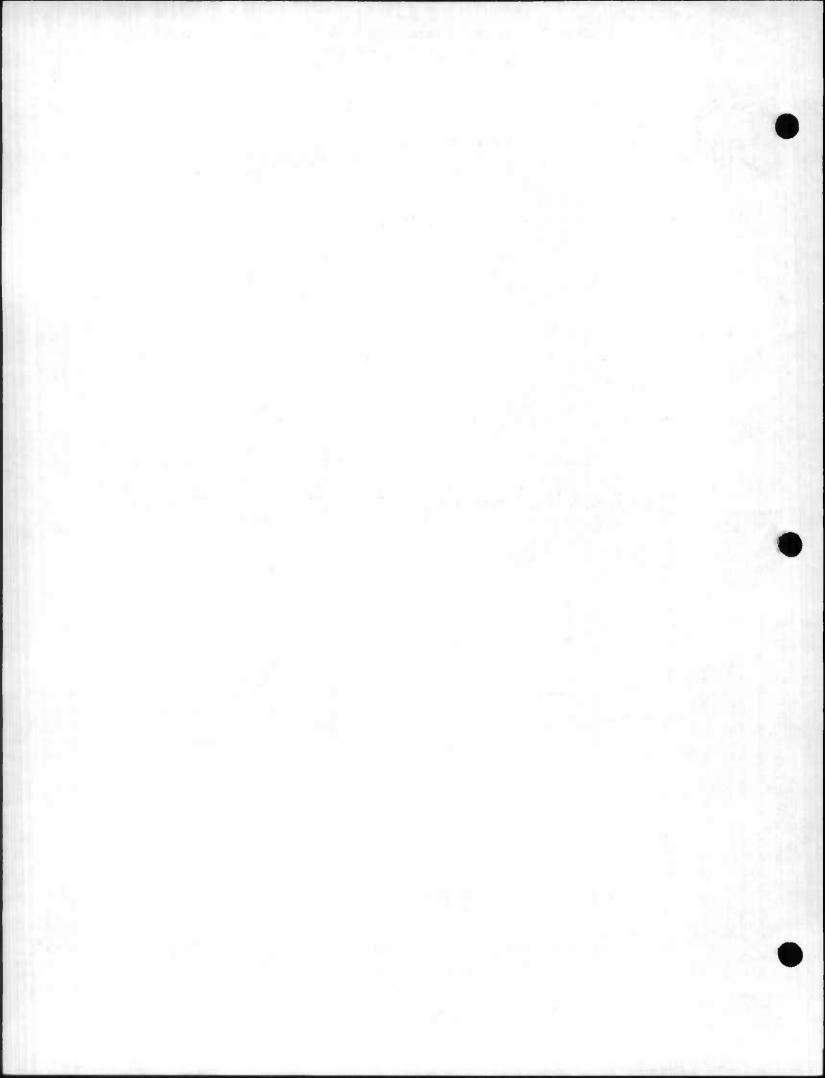
600 North wolf sweet, Tower 110, Balhmore, Maryland 21287 Melanie Katzman 32. Registrar's Signature 31. Date filed (Month, Dey, Year)
JAN 2 6 1998

Date of Injury
(Month, Dey Year)

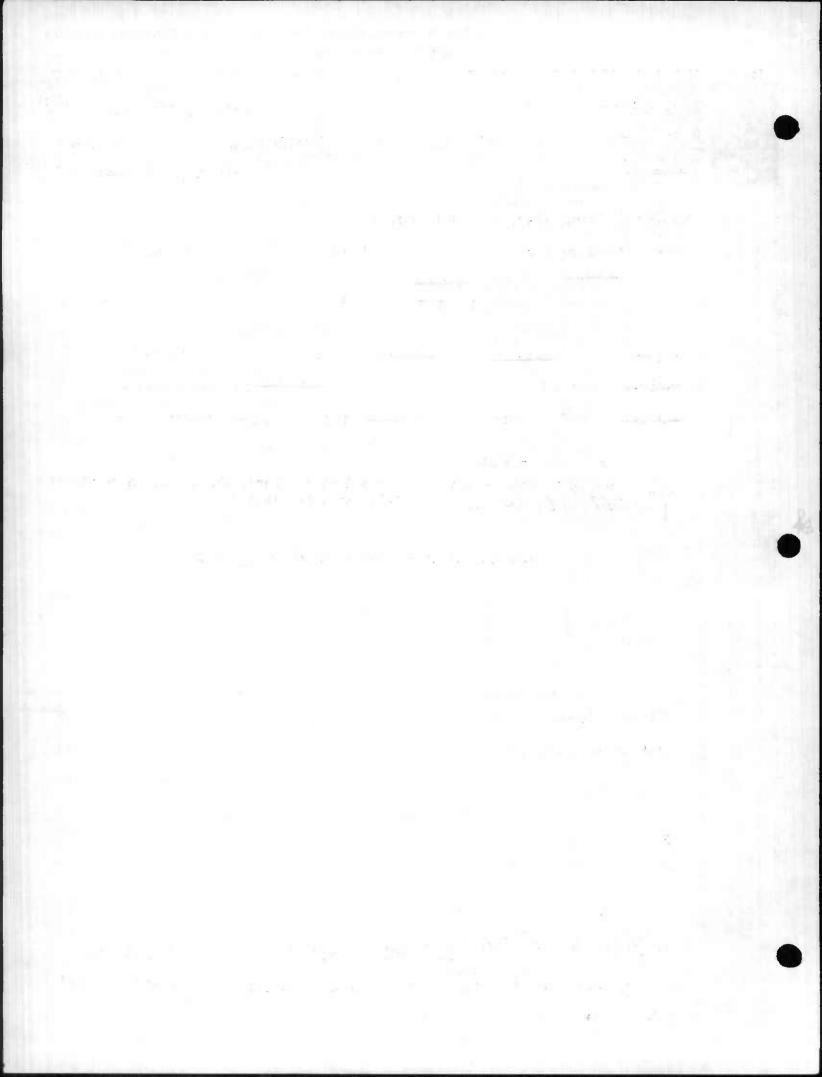
| Section | Description | Company | Compan

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar



State of Maryland / Department of Health and Mental Hygiene Items #5,9,11,12,15,16a,17,18,19,19b per Inf G759 5/20/9 ertificate of Death FOUND 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 03:10 PM JOHN H. THOMAS 001 JANUARY 1998 /Medical FUND 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5029 EDMONSTON 3 RD HYATTSVILLE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Springfield 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 15 M 2□ F Deys Hours Min 64 Yrs. Dec. 1933 Director Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, me Med cal Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Prince Georges Hyattsville Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5029 Edmonston Road 20781 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? unknown 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1953–1957 11. Marital Status unknown 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Š 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Lunknown Chemist unknown nknown unknown permit. Peges 1 end 2 should be file Depertment of Health end Mental Hyr Important: if Itam 27 is marked othe, any injury or other traumatic evant, once. Maryland 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Be Catherine Harrington unknown Hassan S. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) unknown J, Michael Dougherty Pers, Rep _unknown. 11412 Sequoia Lane Beltsville MD 20705 Baltimore, 20b. Place of Disposition (Nama of camatary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donetion 5型Other (Specify) in state 21. Signature of uneral Service Licensee, Wade State Anatomy Board, 655 W. Baltimore Street ade, Director Baltimore, Maryland 21201 23a. art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart feilure. List only one cause on each line. Approximate intervel Betw **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCUEROTIC CARPIOVASCULAR DISEASE Examiner Due to (or as a consequenca of): Examiner The law requires that the death certificate be executed buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. physician Physician/Medicai the Due to (or es e consequence of). for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE Division of Vital Records, by 2 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed PLABETES MELLITUS hes 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funerai 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending 1 Yes 2 No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled In by 4 Homicide 6 Hospital 29a. Certifier Medical 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yaer) 29b. Signature and title of certifie 29c. License number JANUARY 10, 1998 30. Name and address of person who completed cause of death (fem 23a) (Type, Print) OHEVERLY, MARYLAND MARYO F. DRIVE, GOLLE 32 Registrar's Signature 31. Date filed (Month, Dey, Yaer) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month Yaar Robert Eugene Taylor 4:45 pm January 24,1998 4e. Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth - Genisis Eldercare Franklin Woods Rossville Baltimore 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 6 Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stata or Foreign Country) 1 M 2 □ F Deys Hours Yrs. 212 34 2363 Feb. 13,1938 Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Rosedale 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1503 National Road 21237 USA 12. Was Decedant Ever in U,S. Armed Forcas? 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, atc. 11. Marital Status TYPY Yes 2 No If Yes, Give Year or Dates:1957-62 1 Navar Married 2 Married 1□ Yes 2□No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Electrician Steel Mill 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert E. Taylor Bernadette Seltzer 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Delores M. Taylor 1503 National Road Rosedale Maryland 21237 (wife) 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 XBuriel 2 Cremation 3 Removal from State Gardens of Faith Cem 4 Donetion 5 ☐ Other (Specify) 1/28/98 Baltimore Maryland 21. Signatura duneral Sarvice Licanses 22. Name end Addrass of Facility Bruzdzinski Funeral Home PA ations that caused the death Do not enter the mode of dying, such as cerdiac or respiretory erfest,

Approximate Intervel Between Control of the Mode of Do not enter the mode of dying, such as cerdiac or respiretory erfest, mete Onset end Death Immediate Ceuse (Final disease or condition resulting in death) e. SEVERE PERIPHERAL ARTERIAL OCCLUSIVE DIS. 2 MONTHS Due to (or es e consequence of): GANGRENE RIGHT LEG 2 MONTHS Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? complation of cause of death?

Physician /Medical Examiner

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attending physician for use es the burial

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page 2

certificate

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After Attending

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Be Completed

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Certification:

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98

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23a or 28a-f show

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traumetic event, the Medical

permit. Pages I and 2 should be filed within Depertment of Health and Manlel Hygiena. Important: If Itam 27 is marked other then any Injury or other traumetr.

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Physician/Medical

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

25. Was case referred to medical 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of

28e. Date of Injury (Month, Dey Year) 5 Pending investigation 1X Natural 2 Accident 3 ☐ Suicide

6 Could not be determined

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 Yes 2 No

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 ☐ Yes 2 2 No

1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. (Check only 29b. Signetura and Iitla of certifiar

4 Homicide

29c. Licanse number H35593

29d. Date signed (Month, Dey, Year)

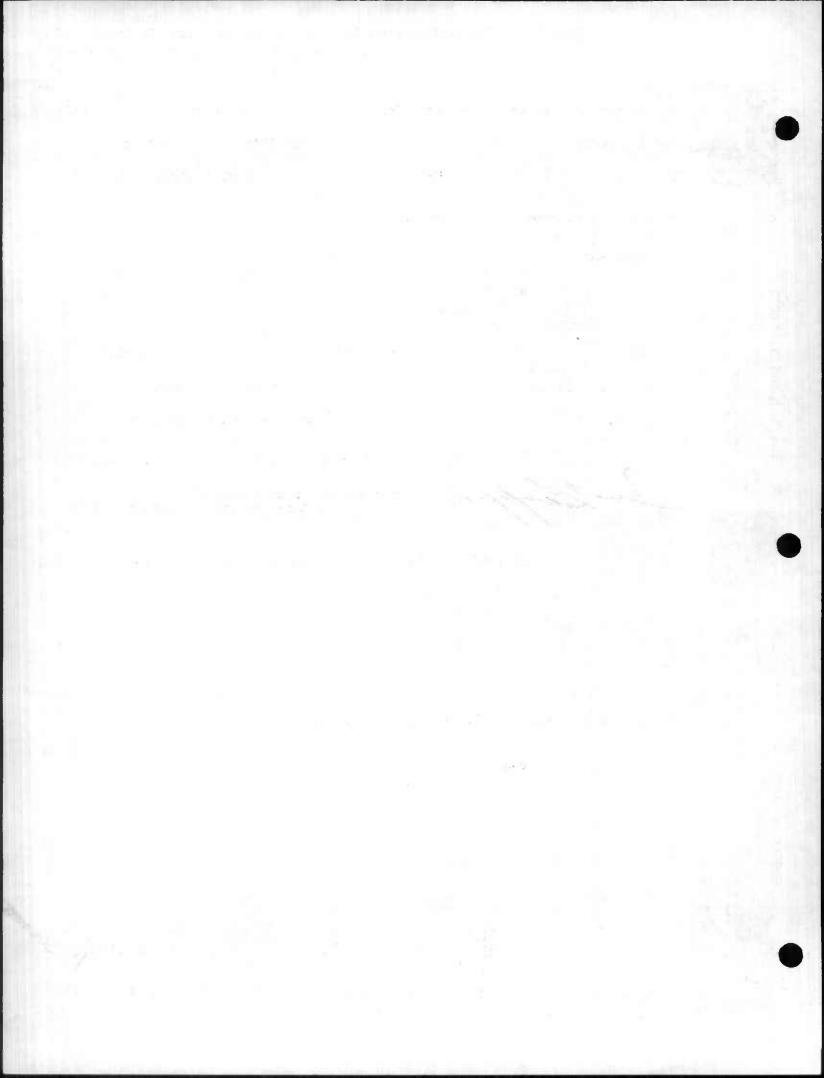
1 ☐ Yes 2 ☐ No

D.O. 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) JAN. 26,1998

DR. JOHN J. LOH

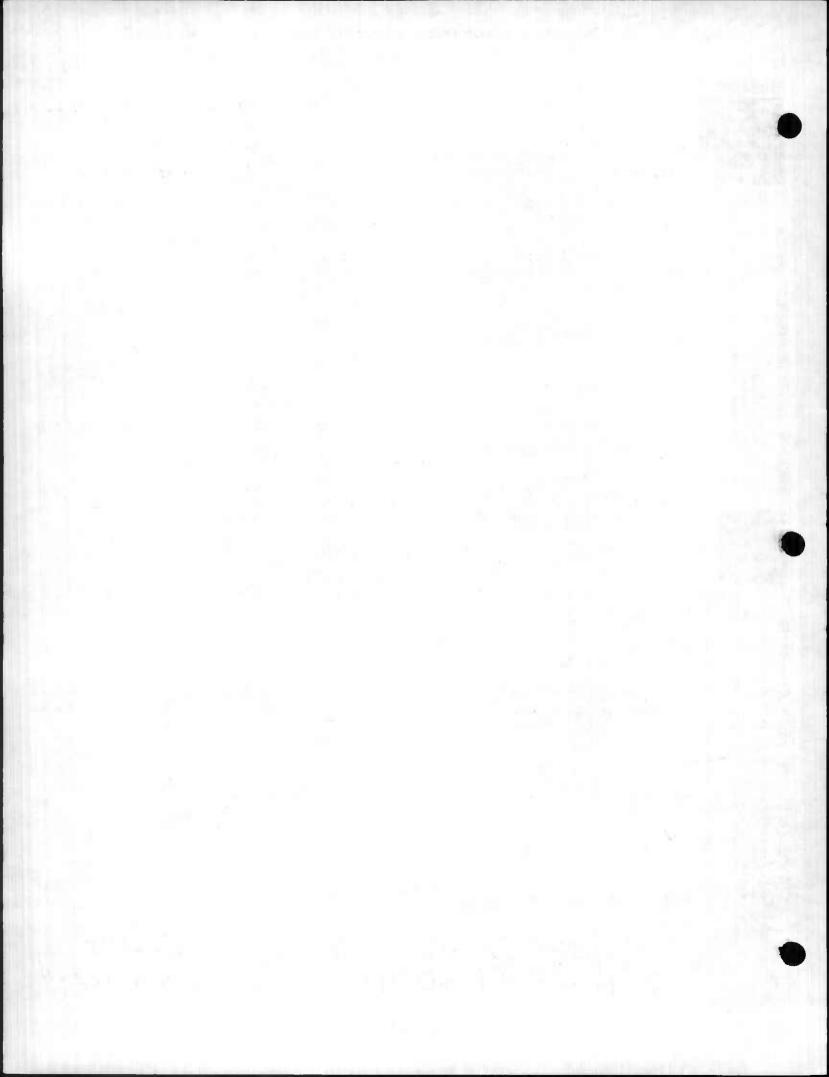
39 Registras Signatures Randelle. BALTIMORE, MD. 21221

State Registrar

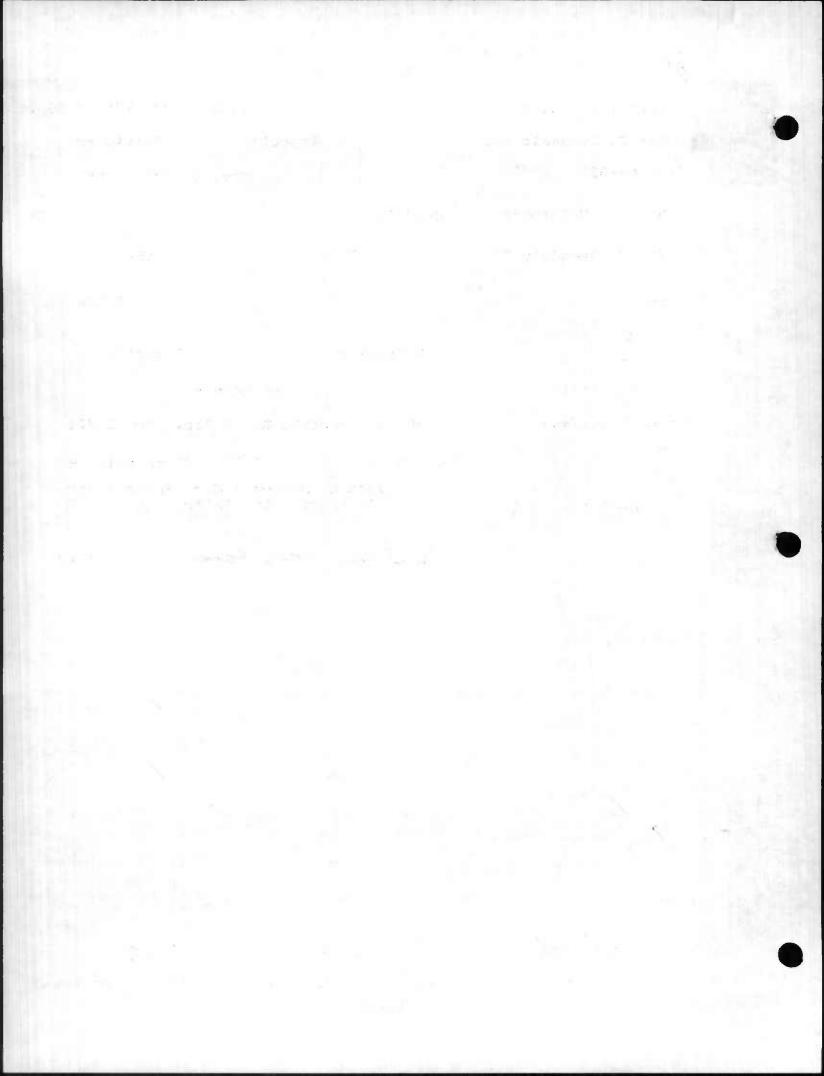


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death		Re	eg. No.	0 (1100	54
			1. Decedent's Nema (First, Middla, Las	st)		21-17	1			2. Data of Deet	h		3. Tima o	f Death
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)	Examir		4a. Facility Name (If not institution, give	a straat and number)				4b. City, To	own, or Lo	ocation of Death	_	nty of Death		
			528 N. Bouldin S.	treet				В	alti			/A		
	uneral irector		212-30-0037	DM affic	(In yrs. last bir 32	thdey) If Unda Months	r 1 Yaa Deys		24 Hrs. Min.	8. Data of Birth (Month, Day, Jan. 9,	^{Yaar)} 1916	9. Birth Cou Mari	piaca (Stata intry) Yland	o <i>r Foreig</i> n
and	ž		Usual Residence of Decadent 10a. State 10b. County	1	10c. City, Tow	n or Location						- T	10d. Insida C	tity I Imite
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d 21215-0020 filled within 72 hours efter death with the Maryland Avoiens.	"natural", or items 23a or 28a-f shor edical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☒ Widowad 4 □ Divorced	12. Was Decedant Ev Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates:		13. Was Dace If Yes, spe				ecify Yas or No- Rican, atc.)		ace - Amari lack, Whita, cify:		
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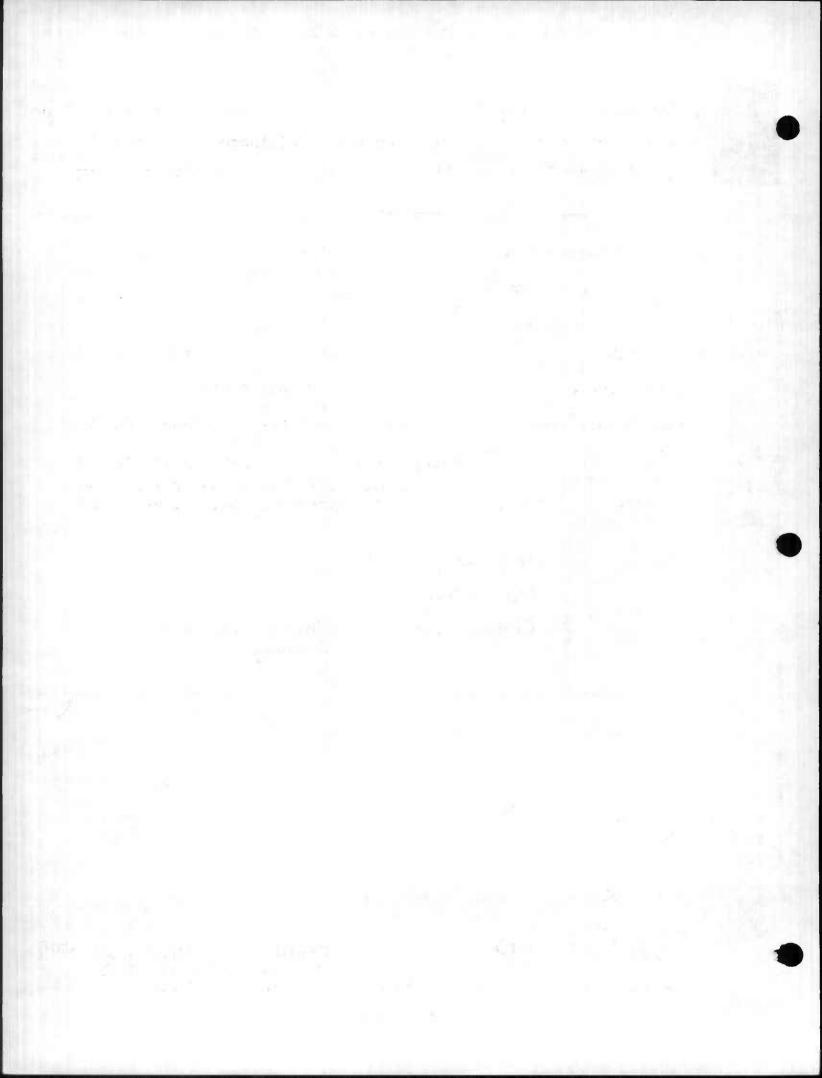


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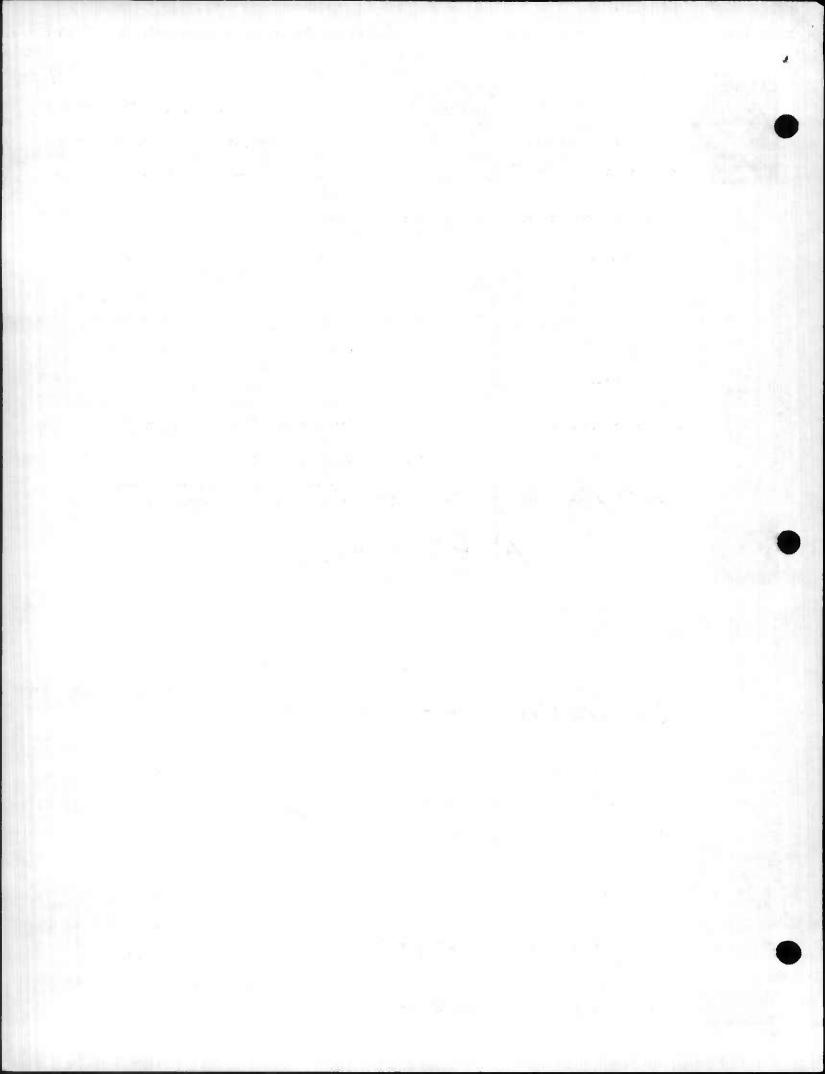
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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death	F	Reg. No. 9		1687
Physic	ian	1. Decedent's Name (First, Middle, Las	t)					2. Dete of Dee Month	oth Dey	Yeer	3. Time of Deeth
/Med		Margare	t	Tohn				January			1:30 PM
Exam	ner	4e. Fecility Neme (If not institution, give	street end number)			4	4b. City, Town, o	or Location of Deeth	4c. County	of Deeth	
	_	Genesis Elderca						allstown		altim	
Funera Director		5. Social Security Number 6. Se 382-03-1348 Usual Residence of Decedent	9X 7. Ag □M 2⊠ F	e (In yrs. lest bii 94	Yrs. Month	der 1 Year is Deys	If Under 24 H Hours M		(, Year)	9. Birthpi Coun H	lece (State or Foreig try) ungary
dend dend		10e. Stete 10b. County		10c. City, Tow	n or Location	-				-1	0d. Inside City Limits
Many Many	ō	Maryland Baltin	more	I	Randall:	stown				}	1 ☐ Yes 2 ☑ No
r 28a	Director	10e. Street end Number			10f. 2	Zip Code			10g. Citizen of	What Coun	try?
h with		9109 Liberty Road	d			21	133		U.S	Δ	
deet Tar	Funeral	11. Marital Status	12. Was Decedent	Ever In U,S.	13. Was Dec			(Specify Yes or No- erto Rican, etc.)		e - Americ	
Maryland 21215-0020 d 2 should be filed within 72 hours efter deeth with the Marylend th end Mentel Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, ha keginal Examinal must be notified at	by	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	40			Specify:	erto Hican, etc.)	Specifi	ck, White, o	hite
5-0 72 ho	Completed	15. Decedent's Ed	ucation	16e.	Decedent's Us	suel Occup	etion	uarde in a	16b. Kind of B	usiness/Inc	dustry
Z La	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT	use retired	during most of w	VOIKING			
filed withi Hygiene. ont, the	Con	10th			House	wife			0wn	Home	
be filed of other	Be	17. Fether's Name (First, Middle, Last)						ame (First, Middle,		10)	
Taryland 2 2 should be filed end Mente! Hygi le marked other aumatic event, I	2	Nicholas	Wah.	L			An	na Ehlin	g		
and series		19e. Informant's Name/Relationship (T	ype, Print)	19b	. Mailing Addre	ss (Street	end Number or	Rurel Route Numbe	r, City or Town,	Stete, Zip	Code)
CENL		Mr. Robert Krimme	1		005 Dee:		d Road	Pikesvil			
Saltimore, semit. Peges 1 er Depertment of Hear mportant: if item: in them: in the more than 10 feet.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ I	Bemovel from State	20b. Place of cemeter	f Disposition (N ry, cremetory or	lame of r other plac	ce)	Date	20c. Location -	City or To	wn, State
Peges nent of I		4 □ Donetion 5 □ Other (Specify,)	Druid	Ridge	Cemet	ery	1/27	Pikes	ville	, MD
DESILITION permit. Peges Depertment of Important: If It any injury or once.		21. Signature of Funeral Service Licens	500		22. Neme	end Addre	ss of Facility	. 1 D/.			
		Stepher	m Har	Kins		_		ral Direc			1122
		23a. Part 1. Enter the disease, or comp shock, or heert feilure. List only	licetions the caused	the death. Do	not enter the m	ode of dyin	g, such es cerd	Randall iac or respiratory ar	rest,	Mil) Z	21133 Approximate Intervel Between
Physician /Medicai Examiner	er	Immediate Ceuse (Final disease or condition resulting in death)	· Ar-	Erico Due to (or es e	SC (e	1164	sir.				Onset end Deeth
death certificate be executed to extending physician end of for use es the bunial-transit	Aedical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting In death) Lest	С	Due to (or es e							
eath certific ettending p			d							<u> </u>	
deat deat	sicia	Pert il. Other eignificent conditione co	ntributing to death be	ut not resulting in	the underlying	ceuse giv	en In Part I.	23b. Did to	obacco use co	ntribute to	the cause of deeth
res that the de signed by the e	by Physician/	Congest				- 1	ure	101	708 2 No	3 Prob	oably 4 Unknow
requi	Completed b				115			24a. Was i perfor		cor	ere eutopsy findings silable prior to mpletion of ceuse death?
The law ate has page 2	E							1DY	es all No		Yes 2□ No
	Bec	25. Was case referred to medical		100			26. Place of D	eath (Check only or	S PERC	1,35	
Physician: Physician: ribis certific	To B	examiner?	Hospital: 1 Inpatie	nt 2 EPVOu	tpatient 3[] t	OOA Oth	"	Home 5 Resid		et (Specifi	0
nding Physiath.		27. Manner of Ceath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у. 286.1	ime of njury M	28c. Injun Worl		28d. Describe h			
prial or Attending Pour affector Affect	Sertification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Plece of Injubulding, etc	ury - At home, fe :. (Specify)	rm, street, facto	ory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
5 5 2	29a. Certifier (Check only one) 29a. Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es state (check only one) 29a. Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es state (check only one)									ated. the ceuse(s)	
To the F within 2. To the F complet	Me	29b. Signature and fifty of certifier		- 0	2	9c. License	e number	1	29d. Date signe	d (Month, I	Dey, Year)
- > - 0) Jee	Hon	ile	30	D20	964				
	1	30. Name end eddress of person who co	ompleted cause of d	ath /ltom-22	Tyme Print)	DZO	304		1-26-9	18	
0							(-11 P	. 3 11 .		0110	2
C.	ate	Jerome H. Ginsberg 31. Date filed (Month, Day, Year)	A2 Padetr	r's Signature		aza M	татт ка	ndallstow	n, MD	2113.	3
Regist		JAN 26 1998	guiageir	bor-Hand	esc.						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** 3:00 pm. Harry Gould Travers /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 706 Walgrove Ct. Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 25,1906 5. Social Security Numbar 6. Sax. 1 M 2 F 9. Birthplace (State or Foraign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 212-07-6173 91 Yrs. Director Usual Rasidence of Dacedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam har must be notified at 1 Yas 2 No Director Maryland Baltimore Reisterstown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code with 706 Walgrove Ct. 21136 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Evar in U.S. Armed Forces? 1 Pas 2 No if Yas, Giva Yaar or Datas: Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 1 Nevar Marriad 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowad 4 □ Divorced White Completed 15. Dacedent's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Baltimore Gas & permit. Pages 1 end 2 should be filed within Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Ma Elementary/Secondery (0-12) College (1-4or 5+) General Supervisor Electric Co. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumema) Be Olga Tschantre 2 Frederick Travers 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 706 Walgrove Ct., Reisterstewn, Md. 21136 Barbara Mercier - Daughter 20b. Placa of Disposition (Nama of cametary, cramatory or other placa) 20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from State 20c. Location - City or Town, Steta East New Market Cem. Jan. 28,1998 East New Market. Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Address of Facility

Eckhardt Funeral Chapel 21. Signature of Funeral Service Lice 11605 Reisterstewn Rd. Owings Mills, Md. 21117 disaasa, or complications that caused the daath. Do not antar the mode of dying, such es cardiac or raspiratory arrest, failura. List only one causa on aach lina. Approximata Intarval Batwean **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) Congestive Heart Foilure Examiner Dua to (or as a consaquance of): Examiner chsuff-concy Remul Sequentially list conditions, if any, leading to Immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 CURDIO MYORUILLY c Ischamic Physician/Medical Due to (or as a consequanca of): gug Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contributa to tha causa of death? signed by 1 Yes 2 No 3 Probably 4 Unknown crth 1 hourt py 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificate Attending Physician: 25. Was casa rafarrad to medical examiner? Be 26. Place of Daeth (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yas 2 No After this 28a. Data of injury (Month, Day Year) 27. Manner of Daath 28b. Tima of Certification: 28c. Injury at Work? 28d. Dascriba how injury occurrad 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant after death Director: / death 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 6 To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to tha causa(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and mennar stated. 29e. Certifiar Medical (Check only one) 29b. Signatura and titla of certifier 29c. Licanse number 29d. Data signed (Month, Dev. Year) Clay Che 022085 JUNUON 26 1998 30. Nama and addrass of person who complated causa of death (Item 23e) (Typa, Print)

State Registrar

J. CLINGUS 31. Data filed (Month, Day, Year) JAN 26

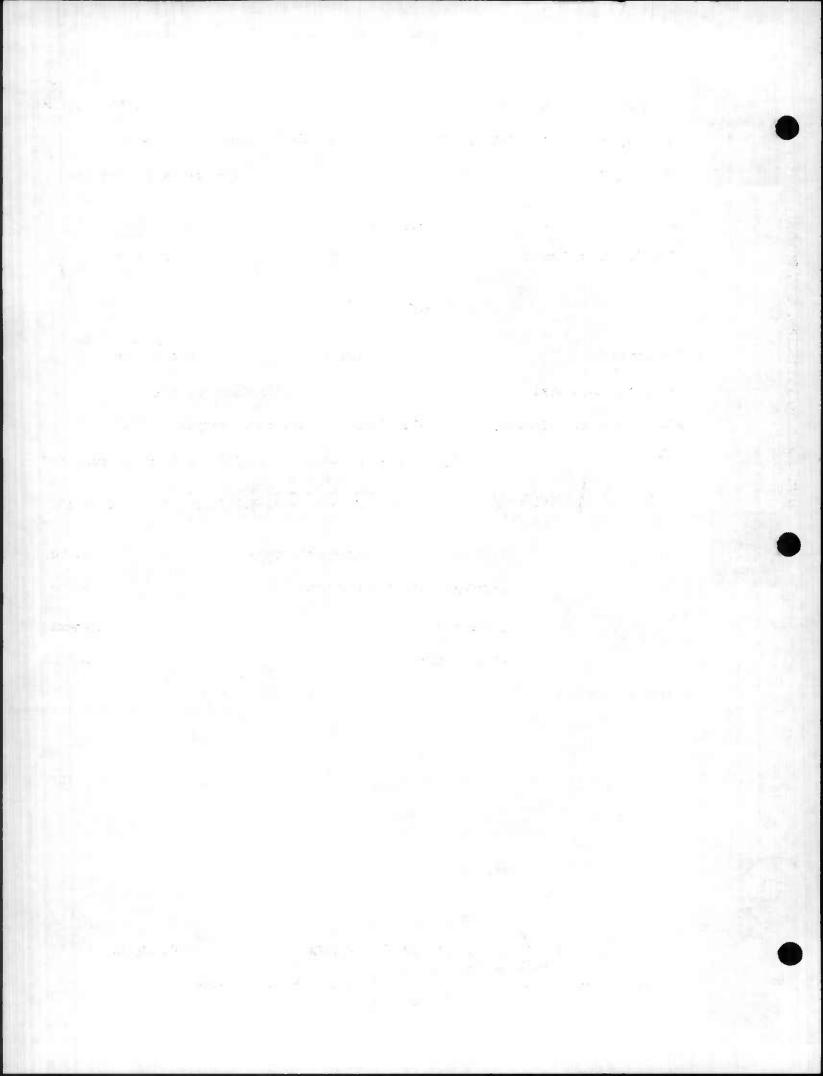


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emilifes herbest - 13 miles and all the eriest tropy - Taylor - Taylor - Taylor Ca., Late tropy No. 2227 THE RESIDENCE OF THE PROPERTY

	_	Decedent's Name (First, Manager 1)	ddle, Last)			Oel	unua	ie or i	Death	2. Date of D		U U	3. Time of Deat	
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miner	-	4a. Fecility Name (If not institu VA Maryland				em		4	b. City, Town, or Perry			ty of Deeth		
ral tor		5. Social Security Number 215–14–8593	6. Sex	M 2□ F	-	s. last birthday) Yrs.	If Unde Months	er 1 Year Deys	If Under 24 Hrs Hours Min	8. Date of B	irth ay, Year) 1, 1922	9. Birthp Cour Ma:	olece (State or Forentry) ryland	
	-	Usual Residence of Decedent 10e. State 10b. Cou	nty		10c. C	City, Town or Loc	cation					1	0d. Inside City Lin	
ctor	N	Maryland	N/A			Balti	more	9					1 X Yes 2□	
Funeral Director		10e. Street end Number					10f. Z	ip Code			10g. Citizen of		ntry?	
erai	-	2038 E. Pratt			edent Ever in	U.S. 13. V	Vas Dece	2123 edent of H		Specify Yes or N		S. A.	cen Indian.	
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Be		17. Father's Name (First, Midd	lle, Last)				ust	ouran		me (First, Middle				
To		Walter Ustas	zewsk	i					Tillie	e Kosmas	zewski			
		19a. Informent's Neme/Relation							and Number or R				Code)	
	-	Sophie Wiedec 20a. Method of Disposition	K (S	ister)		Plece of Dispos cemetery, crem			Baltimo	ore, Mar	yland 2 20c. Location		own, Stete	
		1 ☑ Burial 2 ☐ Cremetic 4 ☐ Donetion 5 ☐ Other		movel from	State	ly Rosa				/23/98	Baltim	ore. l	Maryland	
once. To Be Comp		21. Signature of Funerel Sen	ce License	ne)	22. Sc	Name e	nd Addres	ss of Fecility Funeral	Home In	c.			
an	1	23a. Part1. Enter the diseese shock, or heart feilure. I	or complic ist only one	ations that of	aused the dea	ath. Do not ente	or the mo	de of dyin	s Lane, g, such es cardia	Baltimo ac or respiretory	re, Mar errest,	yland	Approximate Interval Between Onset end Death	
al er		Immediate Cause (Final diseese or condition resulting in death)	е.	De		of the			er's typ	pe			2 years	
iner			h.	C		l Vascul		, .	ent			4	1 month	
Examiner	1	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			Due to	(or es e consequ	uence of):					1 moneth	
edical		thet initiated events	c.	P	neumoni	cor es e consequ	ience of)					2 w		
		resulting in deeth) Lest	d.	Ma	alnutri								6 months	
Physician/M	F	Pert II. Other significant cond	itions contr	ributing to de	eath but not re	sulting in the un	derlying	cause giv	en in Pert I.	23b. Dic	I tobacco use c	ontribute to	o the cause of dea	
D A										1 [Yes 2/ No	3 Pro	bably 4 Unkn	
Completed	-										s en eutopsy ormed?	ev	ere eutopsy finding eileble prior to mpletion of cause deeth?	
		25. Was case referred to med									Yes 2□No	10	Yes 2M No	
To Be	1	exeminer?		spital:	npatient 2[☐ ER/Outpatient	3 D	OA Oth		eath (Check only Home 5 Res		ther (Specif	(v)	
		E LI MOGIGORIE	stigation		of Injury th, Day Year)	28b. Time of Injury	-	28c. Injun Worl	4 □ Nursing Home 5 □ Residenca 6 □ C				,,	
Certification:												umber or Rural Route Number,		
Medical							pocurred at the time, date end place, end due to the cause(s) and stigation, in my opinion, death occurred at the time, date and place.				menner es steted. ce, end due to the ceuse(s)			
Me	one) end manner stated. 29b. Signature end title of certifier					29c. License number 29d. Date signed (Mo					ed (Month,	Dey, Year)		
	· campente mo					MP	D16608 01/19/98							
	3	30. Name end eddress of pers Kam-Ken Let			e of the (Ite	em 23e) (Type, F	Print)	Perr	y Point	. MD 210	02			
	1	31. Dete filed (Month, Day, Ye JAN 26			agistra (Sign	ature do o			, LOINE,	,		_		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 13: 35 DEAN WEDDINGTON JANUARY /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** HOSPITAL HOPKINS JOHNS BALTIMORE N/A 5. Social Security Number 220-64-5314 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 3, 1957 Birthpleca (State or Foreign Country) V A 7. Age (In yrs. lest birthday) **Funeral** Days Hours XXM 2□ F 40 Director Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director MD N/A BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1128 PROCTOR ST 21202 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 X No Specify: BLACK Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOSPITAL 10th N/A HOUSKEEPER 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be HENRY WEDDINGTON MAXINE 2 19a. Informent's Name/Relationship (Type, Print) MAXINE WEDINGTON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1128 PROCTOR ST BALTO, MD 21202 JAN 22 20c. Location - City or Town, Stete 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTO , MD MT. ZION CEM 1998 22. Name end Address of Fecility BETTS FUNERAL HOME 21. Signature of Funeral Service License 1129 N. CAROLINE ST BALTO, MD 21213 LOLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disaase or condition resulting in death) SEPTIC SHOCK Examiner DISTAL ILEUM Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in deeth) Last Dua to (or as a consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? AIDS 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending in estigation 1 ☐Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

and I-transit Box 68760 esn P.O. Records, peen Division of Vital Hospital or Attanding Physician:
124 hours efter death.
 Funeral Director: After this certifical etely filled in by the funeral director, it

the Maryland

deeth

72 hours efter

permit. Peges 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: if flem 27 is marked other than "natural", any Injury or other traumatic average.

Baltimore, Maryland 21215-0020

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, "he Med cal Examinar mast be notified at

Certification: To Medical completely

4 Homicide

(Check only one)

JAN 26 1998

29a. Certifier

Registrar

29b. Signeture end title of certifies

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

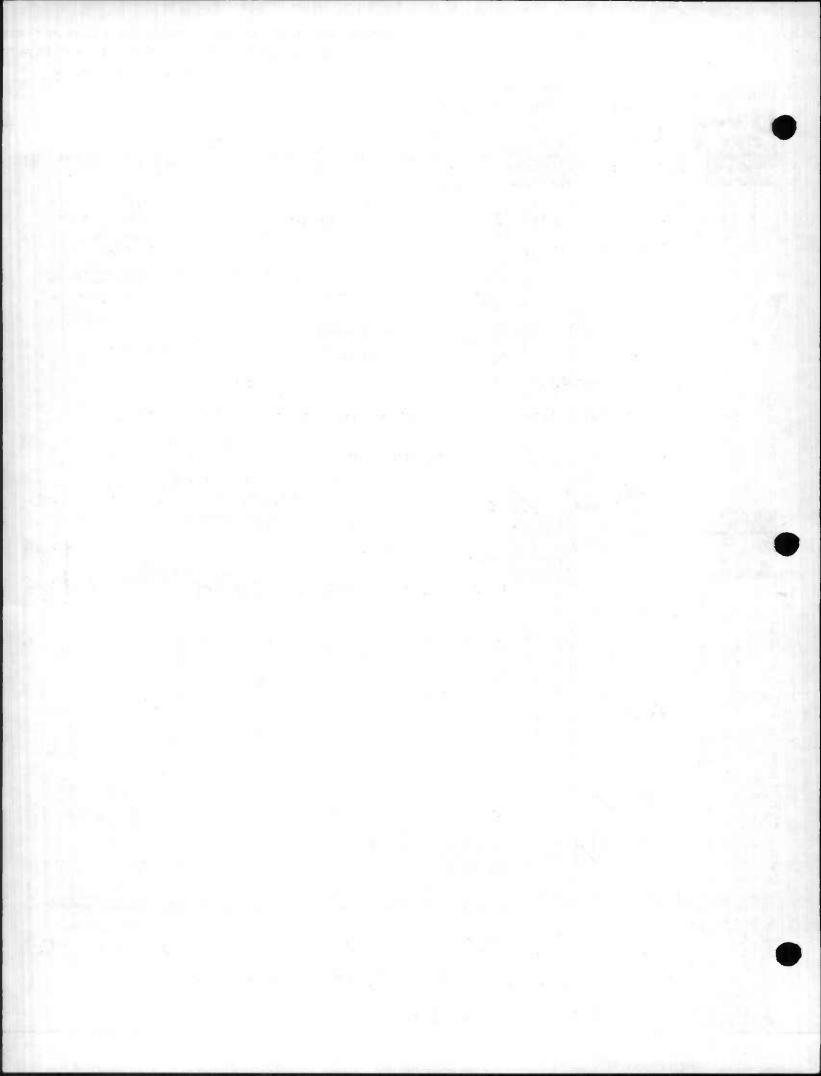
Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

STREET. BALTIMORE, MD, 21287 600 NORTH WOLFE 31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month arolean 4b. City, Town, or Location of Death 21, 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth If Undar 1 Year 1 If Under 24 Hrs.

Manths Deys Hours Min.

OCT 22, 1 **Examiner** Nursing Home 7. Agg (In yrs. last birthday) Care Manor 9. Birthplece (Steta or Foreign Country) VA 5. Sociel Security Number 6. Sex **Funeral** 1□M 2√F 68 Yrs. 1929 Director 577-36-9416 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show r than "natural", or items 23s or 28s-1 short the Modical Examiner must be notified at N/A BALTO Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 926 N. CASTLE ST 21205 U . S . A .

14. Race - American Indian,
Black, Whita, atc. 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas XIXNo If Yes, Give Yaar or Dates: Was Dacedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: À Specify: XXWidowed 4 Divorced BLACK Completed 15. Decedent's Education (Spacify only highast greda completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Haalth end Mental Hygiene. ant: If item 27 is marked other than "I ury or other traumatic event, it a Men Elementery/Secondery (0-12) 8th College (1-4or 5+) N/A UNEMPLOYED Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meidan Sumema) Be ALAMEDIA FERGUSON JAMES BERKLY 19a. tnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) BETTY FLOWERS 926 N. CASTLE ST BALTO, MD 21205 20b. Place of Disposition (Name of cametery, cremetory or other pl 20a. Method of Disposition JAN 27 20c. Location - City or Town, Stete ty Bunal 2 □ Cramation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1998 BALTIMORE, MD 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signatura of Furieral Service Licenses 1120 N. CAROLINE ST BALTO, MD 21213 ucia Della 23e. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximate Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel disaase or condition resulting in death) Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 68760, Physician/Medical to (or es e consequence of): P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. ð 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy page 2 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatienf 3 ☐ DOA Other: Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No this 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel deeth. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attended within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide Contining Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

Light Hadisal Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29a. Certifier

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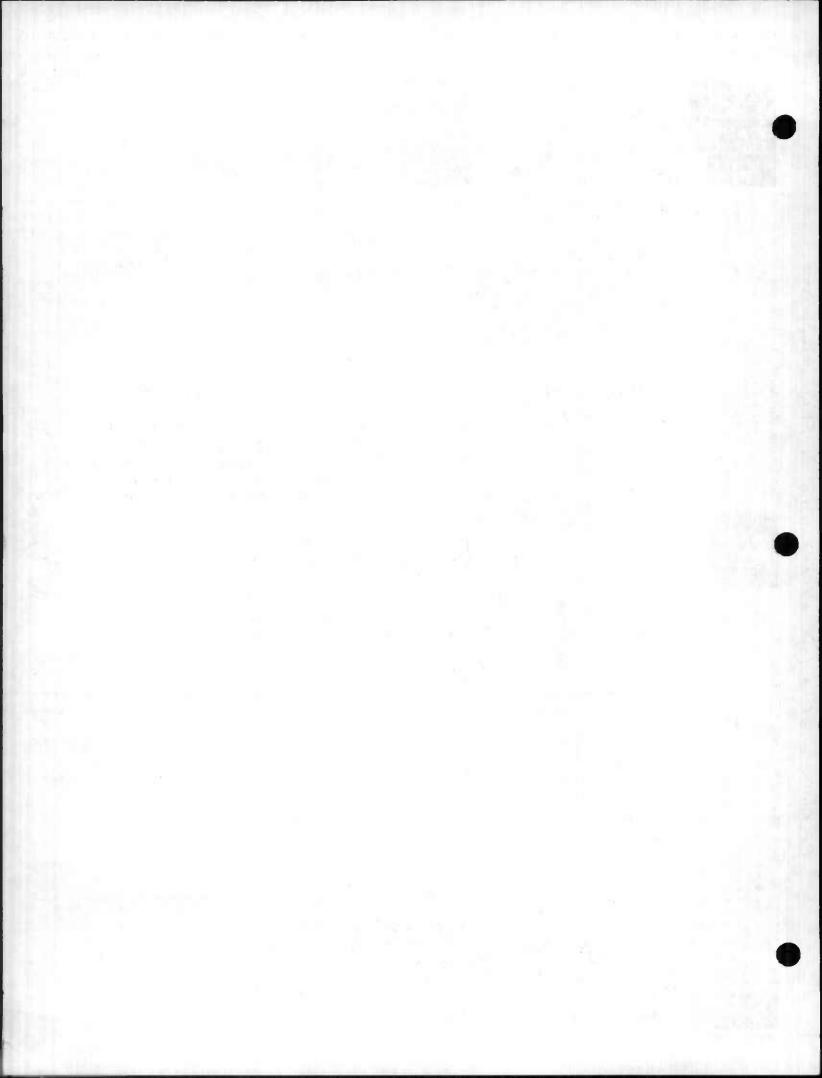
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32. Registrer's Signature

agn who completed cause of death (then 25) (Type, Print)

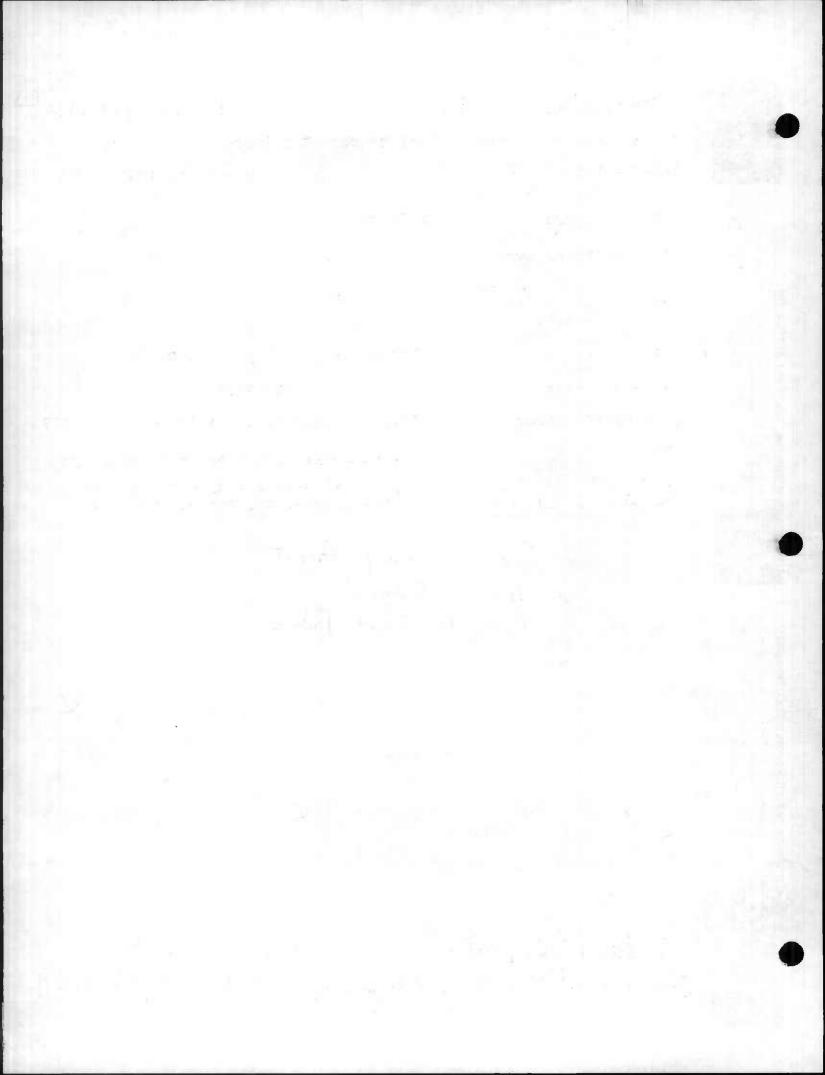
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29d. Data signed (Month, Day, Yeer)



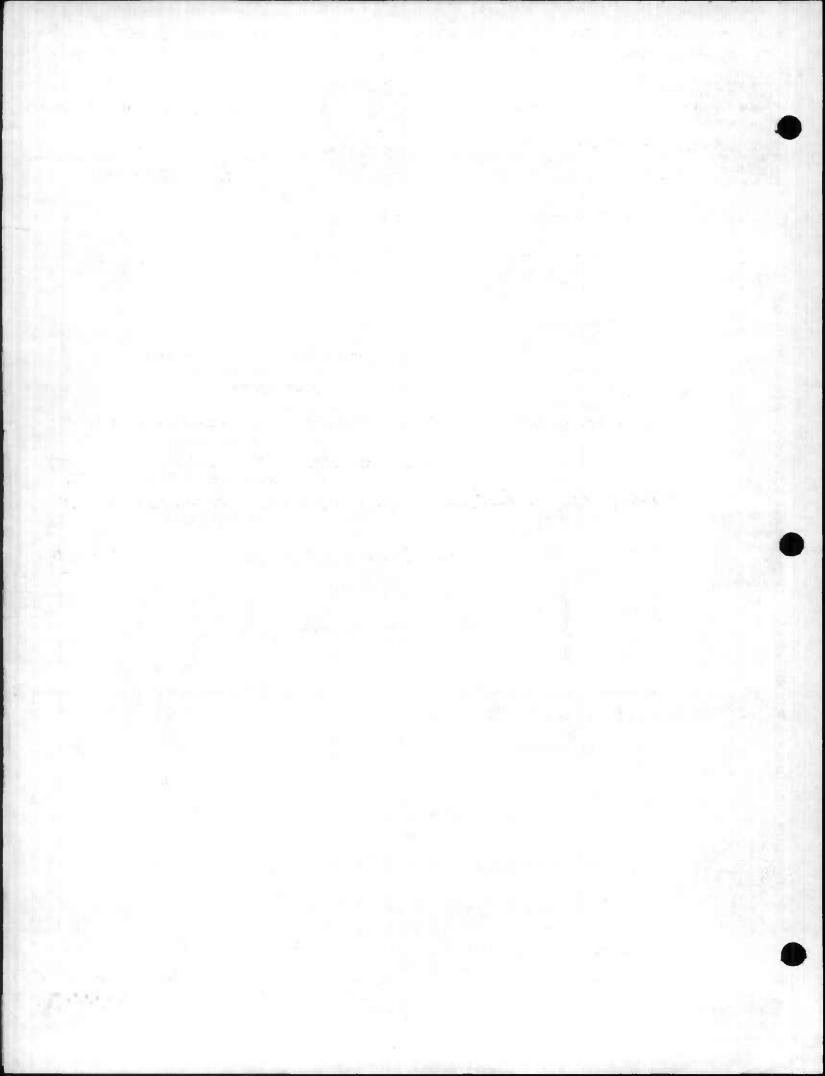
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** evel /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Johns Hopkins Bayview Medical Center **Baltimore** n/a If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (Stete or Foreign Country) 1 M 2€ 95 Yrs. Director 212-36-6718 March 28, 1903 Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location Phow 10d. Inside City Llmits the Medical Examiner must be notified at Director MD XIII Yes 2 □ No n/a Baltimore 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò itema 23a 1932 Walbrook Ave. 21217 Funeral USA be filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo If Yes, Give Maryland 21215-0020 ò 1 ☐ Yes 25 the Specify: Specify: Black þ 3 Divorced 4 □ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be permit. Pages 1 end 2 should be Depertment of Health end Mental Important: If itam 27 is merked any injury next. end Mental Is merkad of Steven Parker P Ella Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lydia Mills/mother 3210 Westwood Ave. Baltimore, MD 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 1/30 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD of Funeral Service Licensee 22. Name and Address of Fecility James A. Morton & Sons Funeral Home 23a. Part1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock of learn feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Horrest 10 Money 0 **Examiner** o (or as e consequence of): Examiner temos, Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest P.O. Box 68760, The lew requires that the death certificate be Physician/Medicai Due to (or as e consequence of): the Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the cause of deeth? 3 Probably Unknown 1 ☐ Yes 2 ☐ No sion of Vital Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? certificate has 1 🗆 Yes 1 ☐ Yes 2 ☐ No Ittending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident the To the Hospital constitution within 24 least least To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) p 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of continue 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name a d address of person completed cause of deeth (Item 23a) (Type, Print) Hopkin Buy view Circle Balt, MD 21224 0 Loone, ill 5505 ohn h 31. Date filed (Month, Day, Year) JAN 26 1998 32. Afgistrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Q 8

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** January 13 ALDON 1998 **KELSO ANDREWS** 0450 /Medical 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath **Examiner** 4c. County of Death Dorchester General Hospital Cambridge Dorchester 7. Aga (In yrs. last birthday) | If Under 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 78 | Yrs. | Months | Days | Hours | Min. | (Month, Day, Year) | April 4 1919 6. Sax 2□ F 9. Birthplace (Stata or Foreign Country) Maryland **Funeral** 220-01-9071 Director Usual Rasidence of Daceden 10a. Stata 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Dorchester Andrews Director 1 Yas ZONO 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 2475 Andrews Rd. 21626 U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forcast 1 ☐ Yes 22 No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) Race - Amaricen Indian, Biack, Whita, atc. 1 Never Married 2 Marriad 1 Yas 2 No Specify: White Spacify: by 3 ☐ Widowed 4 ☐ Divorced Adon Andrews Be Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Pagas 1 and 2 should be filed within mant of Health end Mental Hygiane. Elamantary/Secondery (0-12) College (1-4or 5+) truck driver-chauffer lumber mill 4 pernit. Pagas 1 and 2 should be filled i Depertment of Health end Mental Hygis Important: If itam 27 is marked other i any injury or other traumatic event, ur 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) George R. Andrews Margie Н. 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code) Mrs. C. Priscilla Andrews-wife 2475 Andrews Rd., Crapo MD 21626 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Othar (Specify) Dorchester Memorial Park 1-15-98 Cambridge, Maryland 21. Signatura of Funeral Sarvice Licensee 22. Nama end Addrass of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Pert1. Entar tha diseasa, or complications that caused the laath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, shock, or heart feilura. List only ona causa on each lina. Approximata Intarval Between Onsat and Death Physician /Medical immadiata Causa (Finel disaasa or condition rasulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immadiate causa. Entar Undarlying Causa (Disaase or Injury that Initietad avants rasulting In daath) Last Box 68760. Physician/Medical P.O. I Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Records, Completed 24b. Wara autopsy findings eveilabla prior to completion of ceusa of daath? 24a. Was en eutopsy performed? cartificate hes 1 Yas 2€ No 1 Yes 2 No Attending Physician: 25. Was cesa rafarred to medicel Be 26. Piaca of Death (Chack only ona) 1 Yas 27 No 27. Mannar of Death 10 Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Inpatient 2 ER/Outpatient 3 DOA this funeral Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 5 Pending daath. 1 ☐ Yas 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homicida

Division of Vital

spital or Attendi nours after daath neral Director: A To the Hospital of within 24 hours a To the Funeral D complately filled in

28a. Place of Injury - At home, farm, streat, factory, office building, afc. (Specify)

29e. Cartifier Certifying Phyaicien: To tha best of my knowladga, deeth occurred at tha tima, data and place, end dua to tha cause(s) end mannar as steted.

Medical Examinar: On tha besis of axamination end/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to tha cause(s) and manner stated. 29b. Signatura and title of certifier 29c. Licansa numbar

D0050987

29d. Data signed (Month, Day, Year)

30. Name and addrass of person who complated cause of death (Itam 23a) (Typa, Print)

Aurora street Cambridge MD 266 105

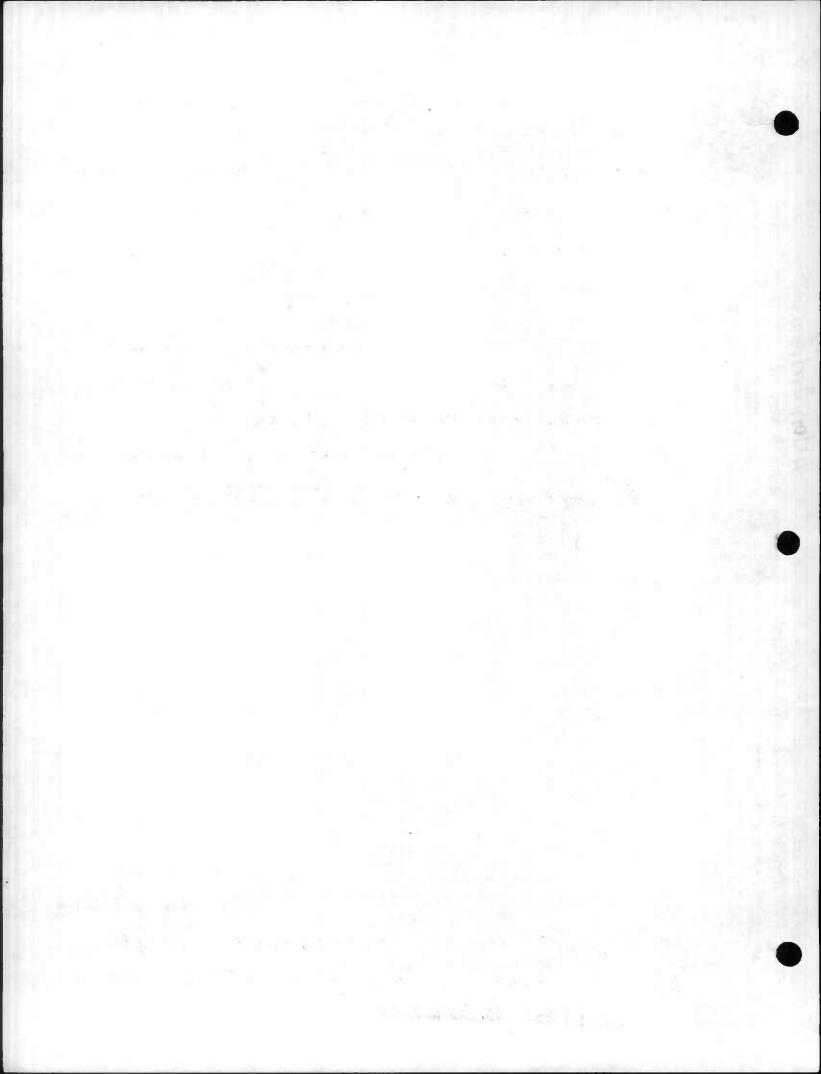
31. Deta filad (Month, Day, Year)

32. Fanstrar's Signatura John Stwelson-Kardall

Medical

State

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Hollie R. Bradshaw 10 98 0350 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1₩ M 2₩ F 60 265-66-6928 Yrs. Director Maryland Sept. 6,1937 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits man 23a or 28a-f show 1 ☐ Yes 2 No Rhodes Point Director Maryland Somerset 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21824 3444 Smith Island Road USA death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 7 is marked other than "natural", or items traumatic event, the Medical Evantiner in filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Seafood Waterman Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Peges 1 end 2 should be nent of Health end Mental Edgar F. Bradshaw Lula Pearson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) or other tra 3444 Smith Island Road - Rhodes Point, MD 21824 Virginia L. Bradshaw (wife) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete permit. Pege Department of Important: If any injury or once. 1/13/98 Calvary Church Cemetery Rhodes Point, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Edneral Service Licenses

Cu W// Service Licenses

Robert H. Bradshaw 22. Name and Address of Fecility
Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Examiner Due to (or as e consequenca of): Examiner The law requires that the death certificete be executed buriel-transil Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequença of): P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of) USB BS Por ed by the ed Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings evallable prior to completion of cause of deeth? Completed director, page 2 should 24a. Was en eutopsy peen this certificete hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 Yes 2 No of funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury et Work? After Division 5 Pending investigation 1 X Natural 1 Yes 2 No death. efter death 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D03599 1 - 10 - 98DME elide 30. Name end address of person who completed cause of deeth (Ilem 23e) (Type, Print) Bulkeley, M. D.
32. Register's Signature 108 Pine Bluff Rd. Salisbury, Md. 21801 31. Dete filed (Month, Day, Year) State Jeli Saveles Rardall Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical	ıl -		MITCHEL		BONNEV			January	12, 19	Yeer 998	11:05 AM
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uneral rector		5. Social Security Number 216–14–2011	6. Sex 1 2 M 2 □ F	7. Age (In yrs. 80	. last birthday) Yrs.	If Undar 1 Year Months Days		8. Dete of Birth (Month, Day, Nov. 1	Year)	9. Birthpla Count Mar	ace (State or Foreign) yland
how In		Usuel Rasidence of Decedent 10a. Stete 10b. County		10c. C	ity, Town or Loc					10	d. Inside City Limit
be notified	BCTO		merset		Me	arion Sta	ation				1 ☐ Yes 2 🔼 N
23a or 2		10e. Street and Number 29879 Hudson	Corner Ro	ad		10f. Zip Code 218	338	1	0g. Citizen of V USA	Whet Count	ry?
ef, or items 23s or 26s-f show Examiner mant by notified at the Finneral Director	2	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece Armed For ied 1 Tes If Yes, Giv Year or Da	rces? 2 No e		Vas Decedent of I I Yes, specify Cub	dispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Ricen, etc.)		ce - Americe ck, White, a v: Whi	tc.
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traumetic	-	19a. Informent's Name/Relations			19b. Mailin	g Address (Street	and Number or Ru		City or Town,	State, Zip (Code)
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= 5		20a. Method of Disposition 1 Burial 2 □ Cremetion 4 □ Donetion 5 □ Other (S)		State	cemetery, crem	sition (Name of natory or other pla		Deta :	20c. Location · Marion		ion, MD
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 01 14 1910 BENTON DANIEL 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY 6. Sax 1 M 2 ☐ F If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Data of Birth (Month, Day, Year) 05/16/1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 215-07-0951 87 Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Somerset Maryland Deal Island 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 23183 Edelen Webster Road 21821 U.S. 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 2 No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. 1 ☐ Nevar Merried 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Transformer Technician 8 Electrical 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Grover Benton Willie Benton 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) Md 21801 Daniel R. Benton/Son 205 Benjamin Ave., Salisbury 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Johns H. M. Cometeny 1/17/00 Deel Telend

Physician /Medical Examiner

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signed by the e

P.O. Box 68760.

Division of Vital Records.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the Interial director, page 2 should be deteched for use as the bunkel transit

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Examiner

Director

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permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hygiene. Important If Itsm 27 is marked other than "netural" ~ in any injury or other traumatic event.

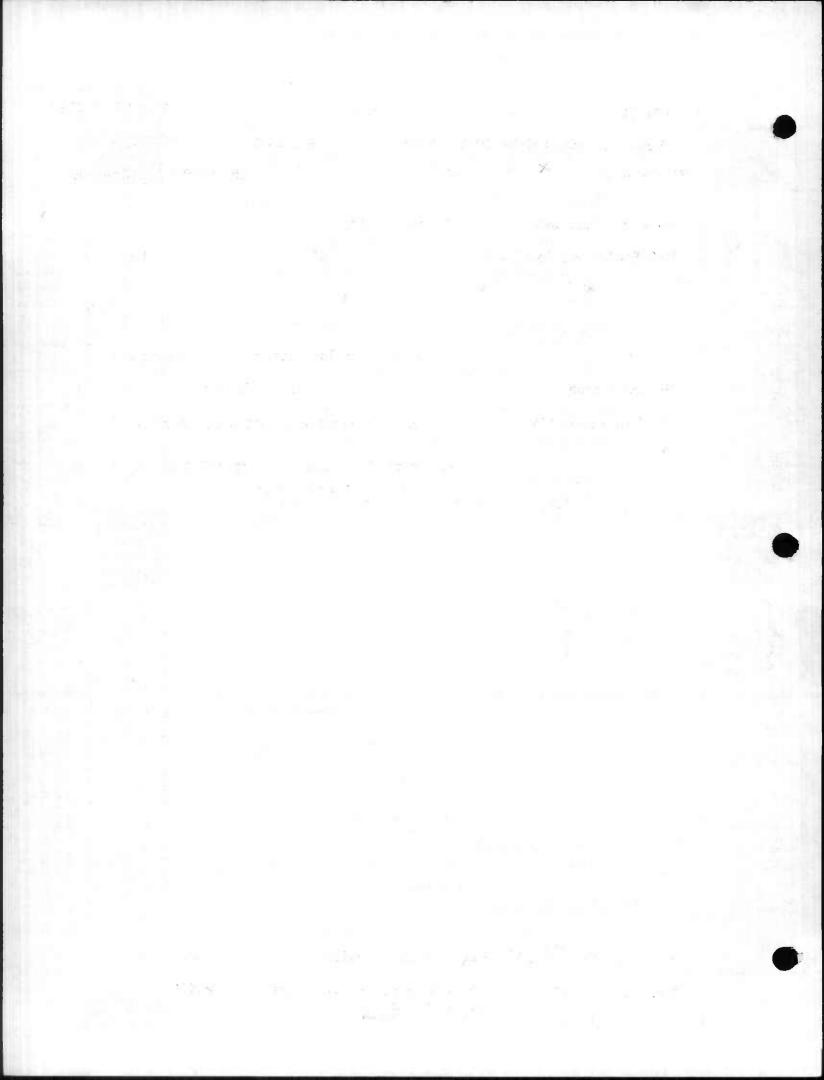
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rasoning in Gaani)	Dua to (or a	s a consequence	of):		
Immediata Cause (Final disease or condition rasulting in death)	e. RESPIRATORY	FAILURE			
shock, or haart failura. Llat onl	y ona causa on aach lina.	Do not antar tha n	noda of dyling, such as card	liac or respiratory errest,	Approximata Intarval Betwee Onsat end Deal
					inco the called
2) Part 1. Entar tha disaase, or cor	(KMCA) M00295	11673	Somerset Av	e., Princess An	ne Md 21853

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801 32. Ragistrar's Signeture

A Sulla Standard Randall

State Registrar

JAN 16



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

					Ce	rtificate	of I	Death			Reg. No.	9 0	1698
nysician		Decedent's Name (First, Middla, Last	st)							2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
Medical		JUNE		BBLE			BAI			1	6	98	0525
xaminer	4	a. Fecility Neme (If not institution, give	e street end nu	imber)			4	b. City, To	wn, or L	ocation of Daatl	4c. Count	y of Deeth	
		PENINSULA REGIO 5. Social Security Number 6. S				If Under 1	Vear	SA If Under	LISB	URY	WICOMI	1	
neral ector	1		DM 2∏ F	7. Age (In yrs. les	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, De FEB . 11	ny, Yeer)	Cour	plece <i>(Stete or Forai</i> ç ntry) VYORK
	1	Usuel Residence of Decedent								I LLD • I I	,1720	INT	IORK
		10a. State 10b. County		10c. City,	Town or Lo	ocation						1	10d. Inside City Limit
rector		MD WICOM:	CO			SALI	SBU	JRY					1 ☐ Yes 2 🔯 N
		10e. Street end Number				10f. Zip C	ode				10g. Citizen of	Whet Cour	ntry?
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Funeral		11. Maritel Stetus	Armed Fo		13.	Was Dacede If Yes, specif	nt of H	ispenic Or n, Mexical	igin? (Sp n, Puarto	ecify Yas or No Rican, etc.)	- 14. Ra Ble	ce - Americ ock, White,	
by Funeral Di		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	ve -		1□ Yes 2]	X No	Specify:			Speci	fy:	TOE
		15. Decedent's Ed	ucation		16e. Dece	dent's Usual	Occup	etion			16b. Kind of E		ITE
Completed	-	(Specify only highest gre Elementary/Secondary (0-12)	de completed) College ((Give	kind of work DO NOT use	done	during mos	t of work	ing			
E		12	2			HOME	MAK	ER			OWN	HOME	
Be		17. Father's Nema (First, Middle, Last)						18. Moth	ar's Nam	a (First, Middle	, Maiden Sume	me)	
2		NORMAN		DIB	BLE			I	RUTH			S	AHR
		19a. Informant's Name/Relationship (7	ype, Print)	5	19b. Mailir	ng Address (Street	end Numb	er or Rur	al Route Numb	er, City or Town	, Stete, Zip	Code)
	-	DEBBIE HORSEMAN	- DAUG			9 MONT		U AV	E	SALISBU		21804	
1	2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removel from	com		osition (Neme metory or oth		e)	i	Dete	20c. Location	- City or To	own, Stete
	-	4 □ Donation 5 □ Other (Specify		. BETI		AEL CE				1-8-98	SAL	ISBUR	Y, MD
once. To Be Completed	1	21. Signature of Funeral Service Licen	PD	1000	22	2. Name and	Addres	ss of Fecili	ty	70.	5 E. MA	IN ST	•
	+	B. Keup	Lithe	m, CF3		BOUNDS					LISBURY	, MD	
		23a. Part1. Enter the diseese, or comp shock, or heert failure. List only	one ceuse on e	ech line.	Do not ent	ter the mode	of dyin	g, such es	cardiac	or respiratory a	rrest,	1	Approximate Intervel Batween Onset and Death
n il	ı	Immadiate Cause (Final							-				Onder and Degin
er	1.4	disease or condition resulting in death)	a				UL	AR	L	DISEAS	€		YEARS
e l	ı			Due to (or e	es e consec	quence of):						ĺ	· ·
Examiner		Sequentially list conditions	b	Due to (or e	s e consec	uence of):						1	
ŭ		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury				, , , , , , , , , , , , , , , , , , , ,							
edical		Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest	C	Dua to (or a	s e consaq	juance of):							
Iclan/Medical Examir													
lan/		feur tree de la constitución de la	d									1	
Physician	F	Pert II. Other significant conditions co	entributing to d	eath but not resulti	ng in tha u	nderlying cau	use give	en In Pert	i.	23b. Did	tobacco use co	ontributa to	o the cause of death
		RHEUM	YATOL	D ART	HRI	TIS				10	Yes 2 No	3 ☐ Pro	bably 4 Unknow
d by			1713							240 Was	en eutopsy	24h W	ere eutopsy findings
Completed	-	ELECT	ROLYT	D ART	ALA	NCE				perfo	rmad?	av	vailable prior to empletion of cause
d E			1										deeth?
		25. Was case referred to medical							15	10		11	☐ Yes 2☐ No
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n: To	2	27. Manner of Deeth	28a. Dete	of Injury 2	8b. Time of		c. Injury						γ)
atio		Naturel 5 ☐ Pending investigation	(Mon	th, Dey Year)	Injury	М		Yes 2	No	28d. Describe how injury occurre			
100		3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At home	a, ferm, str	reet, fectory,	office			28f. Location (City or To		ber or Run	al Routa Number,
Certification:		4 D Homodo	Buildi	ing, etc. (Specify)						Only or 10	wn, State)		
Medical Certification: To Be Com	1	29a. Certifier Certifying Phy	sician: To the	best of my knowle asls of examinetion	edge, deeth	n occurred et	the tim	ne, date en	d plece,	end due to the	ceuse(s) end m	enner es s	iteted.
Pe		one)	end man	ner stated.	11011001111					ou of the (inte,			
2	29b. Signature end title of certifier 29c. License number								29d. Date sign	1			
	D36576 1/6/98							>					
	30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) RONALD P. TRAVITZ MD 560 RIVERSIDE DR, SALISBUR								10	MD 210			
		RONALD P.	IRAU	ITZ_MO) 36	0 141	VE	ESIO	E	12,0	161200	1	10 216
State gistrar	3	31. Deta filad (Month, Day, Yeer) JAN 07 1998	July 1	legistrar's Signatur	ardall								
Julia		01111 01 1000	7										

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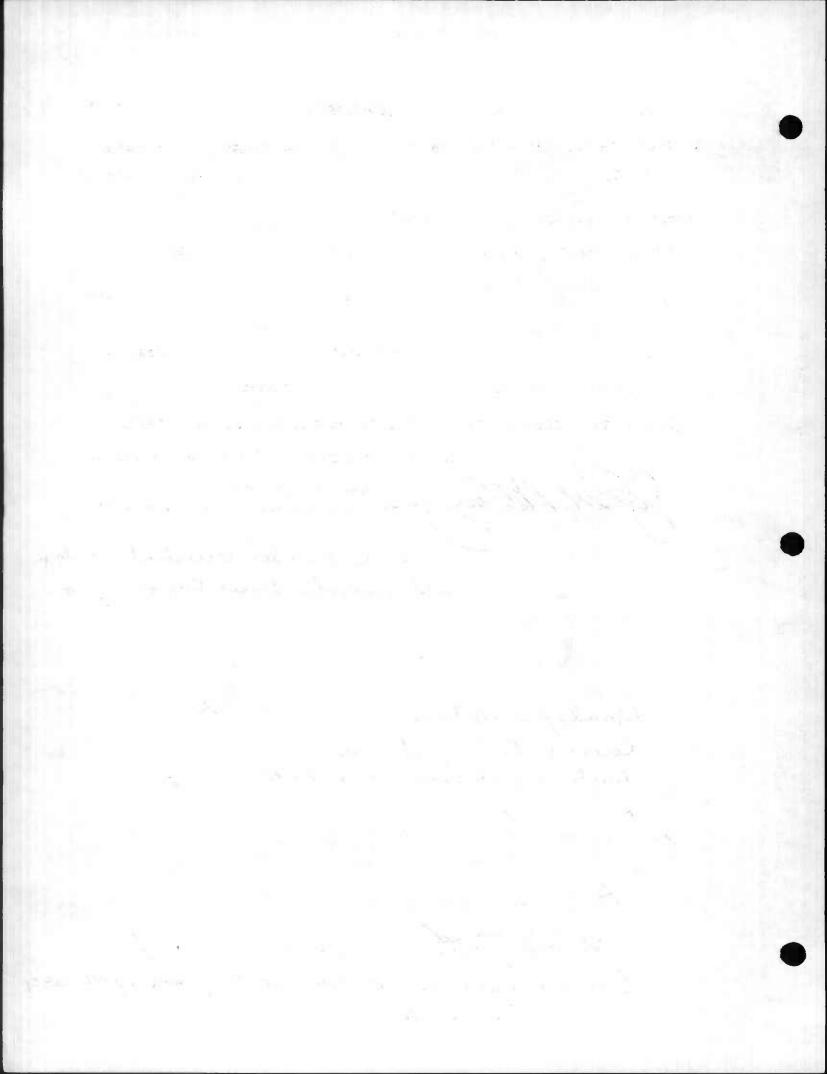
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State of Maryland / Department of Health and Mental Hygien® 9 9 6 9

Physicia		1. Decedent's Neme (First, Middle, Last)									3. Time of Death		
		MARY	RRAN	BRANDENBURG		Month	Dey 3	1998	1651				
/Medic Examin		4a. Fecility Neme (If not institution, g	JANE ive street end numb	ber)	DIVE		4b. City, Town, or			1.0			
Funeral Director		PENINSULA REGI 5. Social Security Number 216–16–4793 Usual Residence of Decadent	ONAL MEDI Sex 7. 1□M 212 F	CAL CE Age (In yrs. le	NTER est birthday) If Unc Yrs. Month	der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	SBURY 8. Date of Bir (Month, De 12/17	th by, Yeer) /19	OMICO 9. Birthple Country Mary	ce (Stete or Foreig) land		
pues **		10a. State 10b. County		10c. City	, Town or Location					10d	I. Inside City Limits		
e Mary	Director	Maryland Wicomi	.co		Sharptown						YOYes 2□N		
death with the Manylend ms 23a or 28a-f show Invest be notified at		10e. Street end Number 417 W. State St	., P.O. I	Box 206		Zip Code 218	61		10g. Citizen of V USA	Whet Country	n		
	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	es? XNo			Hispenic Origin? (Sean, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rec Blac Specify	e - American ck, White, etc : Whit	C.		
	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Housewife					petion during most of wor ed)	ation 16b. Juring most of working 1)			Domestic		
2 should be filed with end Mental Hygiene. is marked other that aumatic event, the Mental or and the M	Be Co	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle					
uld be Aental rked o	To B	(unknown)	Fockler				Unkno	wn					
d 2 should be file th end Mental Hy 7 is marked oth traumatic event		19a. Informent's Name/Relationship	(Type, Print)		19b. Mailing Addre	ess (Street	end Number or Ru	ıral Route Numb	er, City or Town,	State, Zip C	ode)		
D = Z =		Bettie B. Jones/S	Sister-in-	-law	97 W. Ch	nurch	St., Sel	byville					
S to E L		20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3	☐Removal from Sta	ate Ce	ace of Disposition (A	r other ple		Dete	20c. Location -				
Pe nen		4 □ Donetion 5 □ Other (Spec	ify)	Sal	lisbury Cr	remate	ory	1/5/98	Salisbu	ry, M	D		
permit. Departr Importa any inje		21. Signature of Funeral Service Lice	ensee	2			Funeral	Homo					
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Physician /Medical Examiner		Immediate Cause (Finel disease or condition	(/							Inset end Deeth		
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DHMH 16 Rev 6/95



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	Funeral Director		DE M DE	In yrs. lest birthda 57 Yrs.	y) If Unda Months	r 1 Yaar Days	Frede	4 Hrs. 8	B. Date of Birth (Month, Dey	FREDER		e (Stete or Foreign
Aardand	ours effer deeth with the Maryland rail, or items 23a or 28a-1 show Examiner must be notified at by Funeral Director	Usuel Residence of Decedent 10e. State 10b. County Maryland Freder	1	0c. City, Town or	Location derick				<i>/</i> Ct. 20	. Inside City Limits 1 ☑ Yas 2 ☐ No		
O after death with the h		10e. Street end Number 622 Apple Avenue 11. Marital Status 1 Nevar Merriad 2 Married	e . 12. Was Decedant Ev. Armed Forces? 1 ☑ Yes 2 □ No	10f. Zip Code 21701 var in U,S. 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puarto			in? (Speci Puarto Ri		Bled	State e - American ck, White, etc	es Indian,	
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	his certificate al director, pag To Be Col	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 Inpatient	2 ☐ ER/Outpat	ient 3□ D	OA Oth	er.		(Check only o	ne)		as Z NO
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To the Ho	within 24 hours To the Funeral completely filled	(Check only 2 Medicat Example of Contifier on Signature and title of certifier	kamination and/or						29d. Date signed (Month, Dey, Year)			
		30. Name and address of person who	completed cause of dea				CME ., Balt	timor		JANUARY yland 2		198
	State Registrar	31. Dete filed (Month, Dey, Yeer)	32. Registrar's		0							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month 10, MILDRED COHEE January 1998 B. 6:10 A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner McCready Memorial Hospital Crisfield Somerset If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthdey) **Funeral** Birthplece (State or Foreign Country) 1 M 2 M F 75 Yrs. Director 190-16-8958 Sept. 21, 1922 Pennsylvania Usuel Residence of Decadent the Maryland 10e. Stete 10h County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Crisfield Maryland Somerset Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental Hygiene. Important if from 27 is marked other than "natural" or inserting or other trainment. 106 Cove St. 21817 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Yeer or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Seafood Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Wesley Biddle Sadie E. Groce 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred Wells (daughter) 106 Cove St. - Crisfield, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 1/14/98 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Bradshaw & Sons Funeral Home 21. Signeture of Funeral Service Licensee an hist. Ysendlen Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximete intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel 1 DAY diseese or condition resulting in death) Examiner physician end s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, CONGESTIVE Physician/Medical Due to (or es e consequence of) YRS. 98 ERTENSION. signed by the atte Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown COPD by been si 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy Completed certificate 1 Yes 28 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Piece of Death (Check only one) examiner? 1 XYes 2 No Hospitai: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral To the Hospital or Attending Pr within 24 hours etter death. To the Funeral Director: Atter th completely filled in by the funera 27. Menner of Death 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide edicai 29e. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signeture end title of artifier 29c. License number 29d. Date signed (Month, Day, Yeer) Physician. January 10, 1998 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) T. Kanchana, M.D. - 320 W. Main St. - Crisfield, MD 21817 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature. State 1998 > Julia Burden Randall Registrar

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98-0080-045 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. wlc State of Maryland / Department of Health and Mental Hygiene THERESA Certificate of Death Reg. No CROCKETT 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day **Physician** THERESA LYNN CROCKETT January
4b. City, Town, or Location of Death 5, 1998 611p /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner PENINSULA REGIONAL HOSPITAL SALISBURY WICOMICO 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** 1 M 2 F Months Days Hours Min. Yrs. Director 214-60-8531 44 4/21/53 Maryland Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits notified at Maryland Wicomico Salisbury 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or 839 Shad Point Road 21801 USA Funeral death 14. Race - American Indian, 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, its latestance. Bleck, White, etc. 1 ☐ Yes 2 X No If Yas, Giva Yaar or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: White 2 3 Widowed 4 XDivorcad Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Mfg. Seamstress 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Father's Neme (First, Middle, Last) William Kenneth Thomas Phyllis Ann Voigt 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Phyllis A. Thomas/Mother 1517 S. Division St., Salisbury, MD 21801 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Salisbury Crematory 1/8/98 Salisbury, MD 4 Donation 5-1 Other (Specify) o Fungral Service Licens 22. Name end Address of Fecility Holloway Funeral Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Deeth Physician /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequença of) Examiner be executed physician end s the buriel-trans Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): use Po ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performad? Completed peen has 2 No Yes 2□ No certificete Division of Vital director, Be 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XXYes 2 No this funerel 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After Naturei 2 Accident 5 Pending or Attendin efter death. Director: Aff d in by the fur 1 Yes 2 No investigation 6 Could not be 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homiclde Hospital 24 hours e 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner es stated. To the Hosp within 24 hor To the Fune Medicai (Check only one) **Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner stated.

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State Registrar

LAPON COCKB 31. Date filed (Month, Dey, Yeer) JAN 091998

nd title of certifier

29b. Signature

111 Penn Street, Baltimore, Maryland 21201 Registrer's Signature all d'avelor Rardall

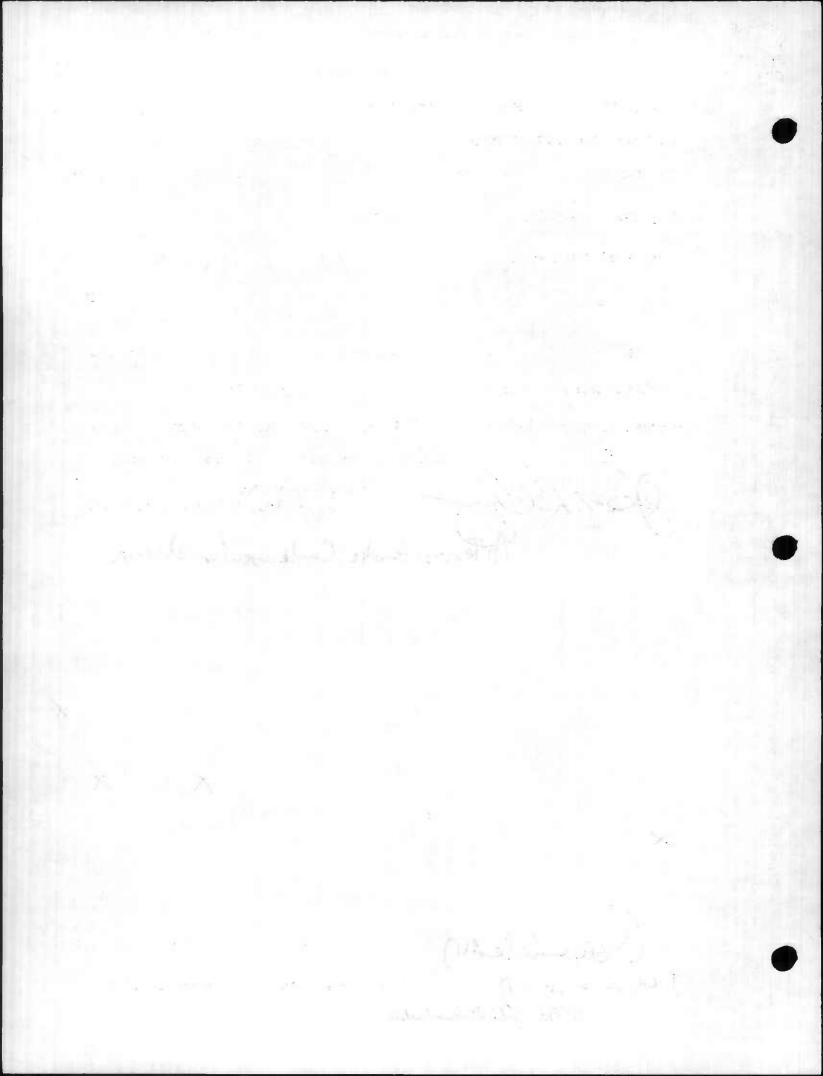
Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29c. Licansa number

O.C.M.E.

29d. Date signed (Month, Dey, Year)

January 6, 1998



AMENDED LINE FORL DES Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** . Month Voor Gertrude Minnie Duva11 0203 an /Medical 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth 4b. City. Town, or Location of Deeth Examiner Washington County Hospital Washington Hagerstown 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) Oct. 2, 1916 5. Sociel Security Number 9. Birthplace (Stete or Foreign **Funeral** 1□M 2ĀF Country)
Maryland 220-40-7243 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryfan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other than "natural". 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23834 Woodfield Road 20882 American 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Talmage Lorenzo Watkins Myrtle Burns 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Myrtle E. Hicks - Daughter 10004 Clearspring Road, Damascus, Maryland 20872 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 □ Burial 2 □ Cremation 3 □ Removel from State 1/4/98 4 Donation 5 ☐ Other (Specify) Upper Seneca Cemetery Germantown, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 23e. Pent1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) Chane ofthedin Pulman Dinear diseese or condition resulting in death) 20 Examiner Due to (or es e consequence of): physician end s the burief-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) guipt for u Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Heart Failer þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen Centro raraber Accident hes page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28e. Dete of injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Affe completely filled in by the fune 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 1 Pertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) - tout mo 018019 Jen 2, (998 30. Name end eddress of person who completed ceuse of deeth (item 23a) (Type, Print)

State Registrar

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31. Dete filed (Month, Day, Yeer)

John Drudeon Real #

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32. Registrer's Signeture

JAN 0 8 1998 John Stevelson Revolette

Maryland 21215-0020

Baltimore,

Box 68760.

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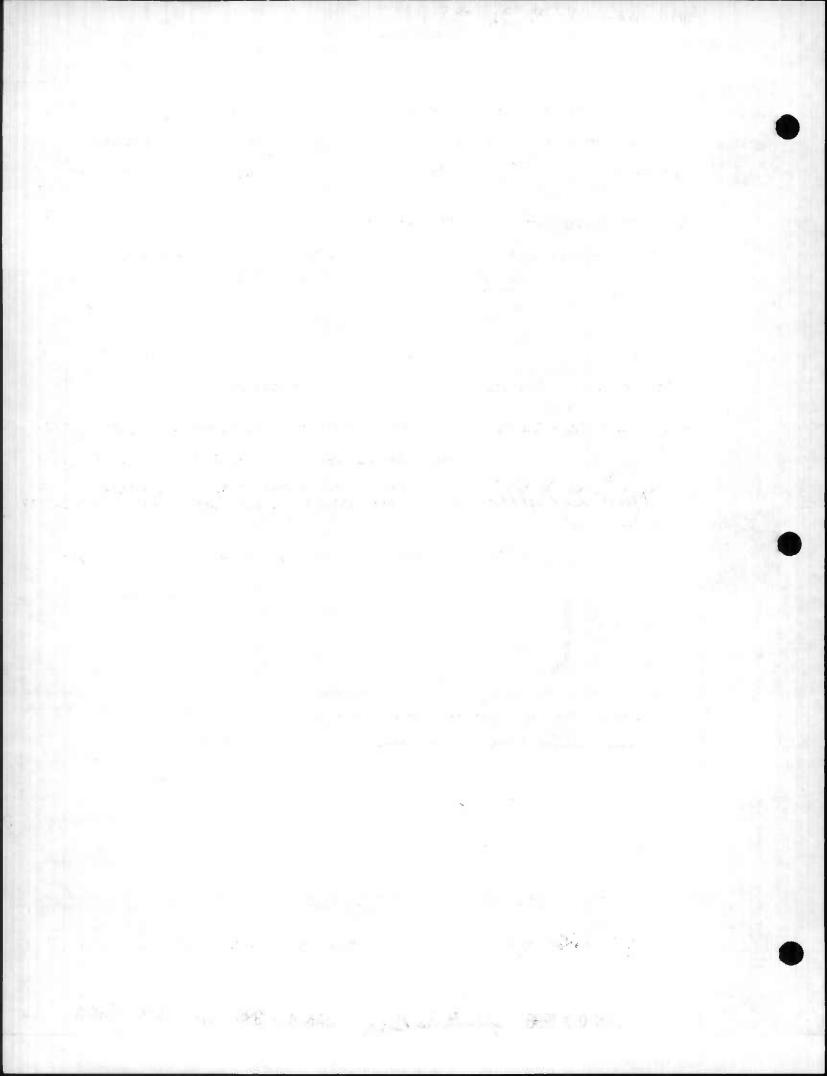
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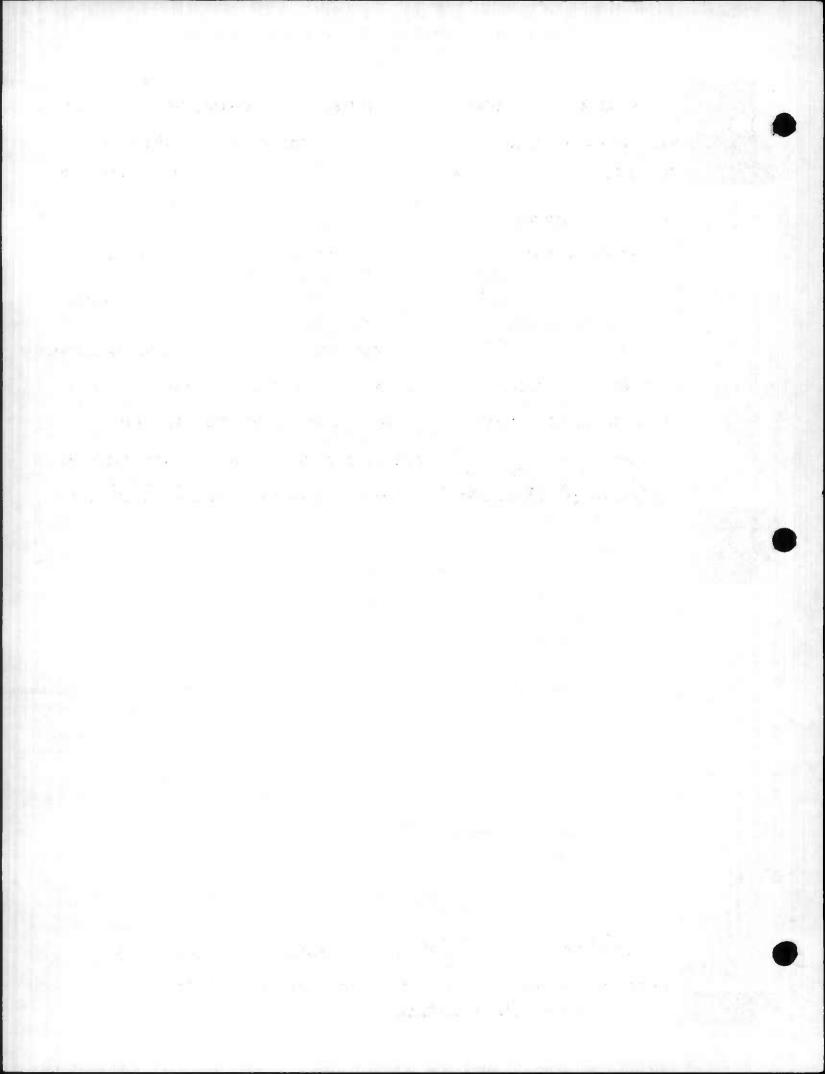
State of Maryland / Department of Health and Mental Hygiene)

Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** January 07 1998 WILLIAM **EDGAR** 3:58 am DAISEY /Medical 4a. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) AUG. 18, 1955 Birthplece (Stata or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys Hours 42 Director 212-66-0625 MARYLAND Usual Rasidance of Dacedant with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ♥ No Director WICOMICO WILLARDS 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? LINE RD. BOX 240D 21874 U.S.A. deeth Funeral Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yas, Giva 1 Nevar Married 2 Merried 1 ☐ Yas 2 ♥ No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) CARPENTER BUILDING CONTRACTOR 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surneme) Peges 1 and 2 should be filment of Health end Mentel Hant: If Item 27 is marked out Be HARRY **EDGAR** DAISEY ELIZABETH DALE TAYLOR 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Depertment of Health et important: if item 27 is any injury or other trau HARRY E. DAISEY - FATHER 35380 E. LINE RD. WILLARDS, MD 21874 20b. Place of Disposition (Nema of 20e. Method of Disposition 20c. Location - City or Town, State Data cematary, crematory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stete 4 ☐ Donation 7 5 ☐ Othar (Specify) PITTSVILLE CEMETERY 1-10-98 PITTSVILLE, MD 21. Signature of Funaral Service Licansee 22. Name end Addrass of Facility 705 E. MAIN ST. SALISBURY, MD 21804 uala BOUNDS FUNERAL HOME Part1. Entar tha diseasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiec or respiretory errest, shock, or haart fallura. List only ona causa on each line. Approximate Intarval Between Onset and Death **Physician** Immediata Cause (Finel disaase or condition resulting in daath) /Medical bua to (or as a consequence of): **Examiner** Examiner tube physician and s the buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated events resulting in daath) Last Oue to (or as a consequence of): certificate be execu Box 68760. Physician/Medical Due to (or as e consequenca of) 98 ettending for use es P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ate has been signed by the page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown vadriplegic - Mentally in um Records, þ 24b. Wara autopsy findings eveilable prior to Completed 24e. Wes en autopsy timenta Binddas Bowell complation of cause of death? certificate has 1 ☐ Yas 2 € No 1 ☐ Yas 2 ☐ No Division of Vital director, Be 25. Was case refarred to medical 26. Placa of Death (Check only ona) Hospitel: Othar: 4™ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) ٩ 1 Yas 2 No 1 Inpetiant 2 ER/Outpatient 3 DOA this al or Attending Physics after deeth.

If Director: After this et in by the funeral d 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 12 Certifying Phyalcian: To the bast of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29a. Cartifiar Medical 29b. Signature and title to certifier 29c. Licansa numbar 29d, Data signed (Month, Day, Yaar) men D02026 30. Nama end address of parson who complated cause of death (Itam 23a) (Type, Print) 1622A Ocean Pines Federico G. Arthes, MD Berlin, MD 21811 31. Data filed (Month, Day, Year) 22. Registrar's Signature State JAN 091998 Registrar

DHMH 16 Rev 6/95

William Edgas



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Jan. FLICKINGER HILDA MARIE 5:40 am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 510 East Baltimore Street Tanevtown Carroll 5. Social Security Number If Under 1 Year if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Yand **Funeral** Deys 1□M 2♥F 217-18-8431 86 Yrs Director Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumstic event, the Medical Examiner must be notified at Director Maryland Carroll Taneytown 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 510 East Baltimore Street 21787 U.S.A. "natural", or items 23a death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Pages 1 and 2 should be filed within 72 hours after and to Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: Caucasian 1 Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) William Zepp Mary Keefer 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Eckard/Daughter 1514 Harney Rd., Littlestown, PA other i 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baust Church Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removal from Stete permit. Page Department of Important: If any injury or once. 01/10 Tyrone, MD 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Skiles Funeral Home Stiles MO0534 136 E. Baltimore St., Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in death) e. Metastatic Pancreatic Carcinoma 3months Examiner Due to (or es e consequence of): Examiner attending physician and for use as the bunal-transit that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? s been signed by t should be detact 1 Yes X No 3 Probably 4 Unknown Hypertensive Cardiovascular Disease λq The law requires Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? page 5 2E No 1 ☐ Yes 1 Yes 2 No this certificata Hospital or Attanding Physician: 24 hours after death. funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Neturel 1 Yes 2 No I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled edicai Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier. 29c. License number 29d. Dete signed (Month, Day, Year) D 14317 Jan. 7, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

One Kings Drive, Taneytown, MD

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signeture in alterdeer hardell JAN 0 8 1998

William R. Linthicum, M.D.

Baltimore, Maryland 21215-0020

Box 68760,

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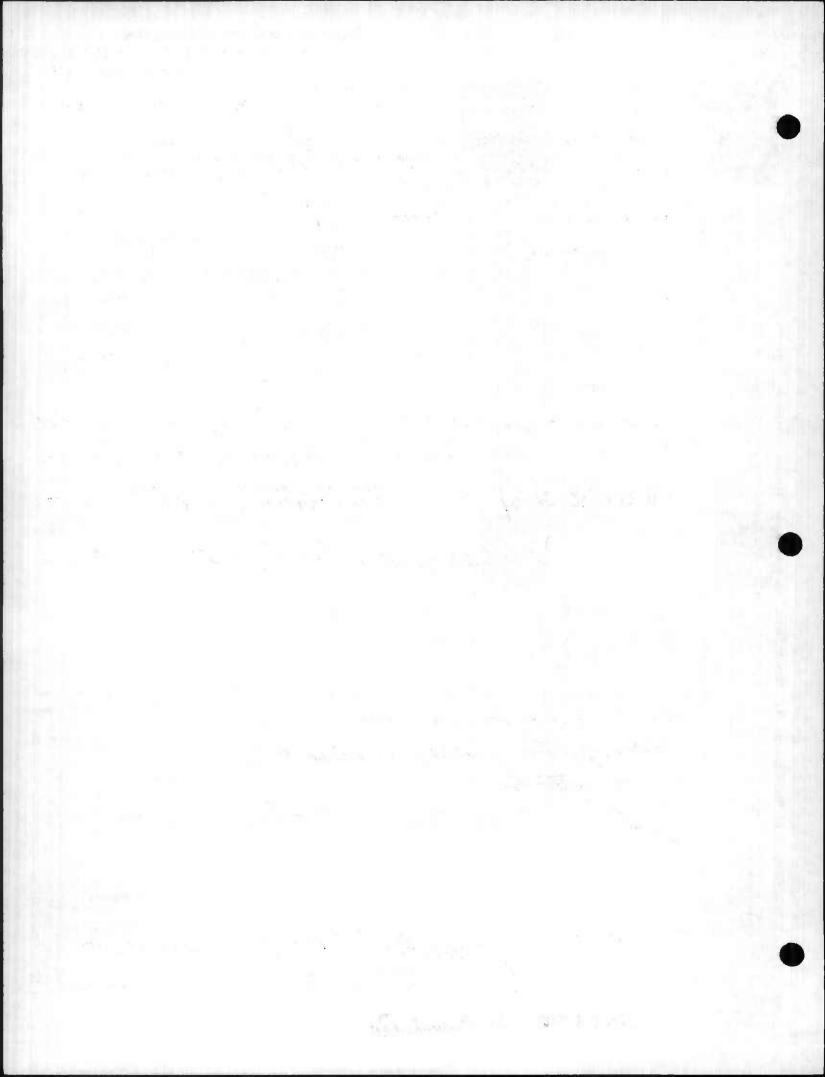
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25. Was case referred to medical adminer? 10 Yes 22 To Hoopital: Impatient 2 ER/Outpatient 3 DOA Other: Muraing Home 5 Residence 6 Other (Specify) 27. Manner of Breith 28a. Date of Injury 28b. Teme of Injury M 1 Yes 2 No 28a. Date of Injury At home, ferm, streat, fectory, office 28f. Location (Street end Number or Rurel Route Nicht) 29a. Certifier (Check only one) 29a. Certifier (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 29b. Signature and little of Certifying Physician: To the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year)	has been s ge 2 should mpleted	ompieted p	regurgeta	lion ,	sei	zei	id	lora	ler,	performe	ed?	ave cor of o	ailable prior to apletion of ceus	
The state of the s	entific ector, Be	1	examiner?	Masshali				-	e of Death	(Check only one))	-		
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29a. Certifier (Check only ene) 29b. Signature and little of Certifier (Check only ene) 29c. License number 29d. Date signed (Month, Dey, Year)	d in by the		2 Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined experiment. Suicide 28e. Place of Injury - At home, ferm, streat, fectory, office								28f. Location (Straet end Number or Rurel Route Number, City or Town, State)			
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State 31. Dete tilled (Month, Day, Year) 32. Registrer's Signature			Ali J	- MA	OOKI	Ch	m)	300	i	9th	St. F.	red	Perick.	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				C	Certificate	of D	eath		Reg. No		11/00	
Physic /Medi		1. Decedent's Neme (First, Middle, Le Martha	Jane	9	FINK			2. Date of Month		y 1998 ^{ear}	3. Time of Dea 10:50 P	
Exami		4a. Facility Name (If not institution, given 421 North Bent					City, Town Frede	or Location of I		County of Deat rederic		
Funeral Director			Sex 7. Age ((In yrs. last birtho	Months		f Under 24 Hours	8. Dete d Monti Jul	of Birth 1, Day, Year) 28, 19:	9. Birt Co 35 Mai	hplace (State or For untry) ryland	
72 hours efter death with the Manyland natural; or items 23a or 28a-f show deal Examinet must be notified at the death of himseld for the part of the		Usual Residence of Decedent 10a. State 10b. County Maryland Freder		Oc. City, Town o	r Location erick						10d. fnside City Lir 1 ☑ Yes 2 ☐	
		10e. Street and Number 421 North Bentz	Street		10f. Zip (071			izen of What Co	untry?	
irs efter death	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U,S.	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto			? (Specify Yes ouerto Rican, etc	or No-	14. Race - Ame Black, White Specify: Wh:	e, etc.	
d within 72 hours eff plane. r than "natural", or	Completed	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(G	ecedent's Usual Rive kind of work fe. DO NOT use	k done dur e retired)	ring most of	working		ind of Business/	industry	
el Hyg	Be	10 17. Father's Name (First, Middle, Last Glen	WERS	mbly Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) Esther Elva WETZEL					ETZEL			
ss 1 and 2 should be f of Health end Mentel I Item 27 is marked of r other traumatic eve	J.	19a. Informant's Name/Reletionship (or Town, State, 2 aryland	Zip Code)	
permit. Pages 1 a Department of Hes Important: if item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of D cemetery,	isposition (Name crematory or oth	e of her place)		Date	20c. Lo	ocation - City or		
entificate be executed with a single physician and sees the buriel-transit	Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse, (Disease or Injury	a. Metas		astas	· C		xwy -	Cun e		2 m.	
ng as	Me	Ceuse (Disease or Injury thet initiated events resulting In death) Last	C. Du	e to (or es e con	sequence of):					1		
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aw requires the the death of the ettences should be detached for us	by Physician	resulting In death) Last	d			use given	in Part I.	24a.		No 3 Pi	vere autopsy finding	
Ine law requires that the death of the last been signed by the ettend page 2 should be detached for us	Completed by Physician	Part II. Other significant conditions of	d					24a.	Was an autor performed?	No 3 Pr	completion of cause	
ang rnystoten: The law requires thet the death of After this cartificate has been signed by the ettend funeral director, paga 2 should be detached for us	To Be Completed by Physician	Part II. Other significant conditions of the con	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	not resulting in the	e underlying car	Other:	26. Plece of 4 □ Nursli	24a. Death (Check on g Home 5 E	Was an autoperformed?	psy 24b. No 6 Other (Spe	were autopsy findinavailable prior to completion of cause of death?	
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1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey **Physician** CLYDE **GRAHAM** 0610 January 8, 1998 /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street and number) 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | DEC • 30 • 1908 If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country)
WEST VIRGINIA **Funeral** 1XM 2□ F Months Days 89 Director 719-05-2149 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show Director 1 ☐ Yes 2 No WICOMICO MARDELA SPRINGS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? o g mart b 9219 MILL BRANCH RD. 21837 U.S.A. Funeral item 27 is marked other than "natural", or itema other traumatic event, the Medical Expriner m 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 X Yes 2 □ No If Yes, Give ARMY Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementery/Secondary (0-12) College (1-4or 5+) 12 POLICE OFFICER COUNTY GOVERNMENT 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be ould be i **GRAHAM** Lo ROBERT NETTIE CRUICKSHANK Pages 1 end 2 should of Heelth end Nitem 27 is mai 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PAT MARSHALL - DAUGHTER 9219 MILL BRANCH RD. MARDELA SPRINGS, MD 21837 20a. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, Stete Department of Inportant: If ite any Injury or ot once. cemetery, crematory or other place) 1 \ Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation □ □ Other (Specify) Other (Specify) SPRINGHILL MEMORY GARDENS 1-10-98 HEBRON, MD 21. Signature of Punerel Service Licenses 2. Name end Address of Fecility 705 E. MAIN ST. BOUNDS FUNERAL HOME SALISBURY, MD 21804 Juala 23a Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset end Deeth **Physician** Pruiring Immediate Cause (Final disease or condition resulting in death) /Medical Examiner The law requires that the death certificate be executed buriel-tren Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lesf got de mug Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? aulitas 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown type 11 Records, þ were auxua, In defenció 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy alternselvotos Cardinacaden 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 Monpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division or Attending 1 Naturel 5 Pending Investigation Injury 24 hours efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. Medical 29a. Certifier completely To the within 2 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number Baldado 8 1998 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

547- F RIVERUSE OFFICE Salei Rusy, 8+114 32. Registrer's Signature 31. Date filed (Month, Day, Year)

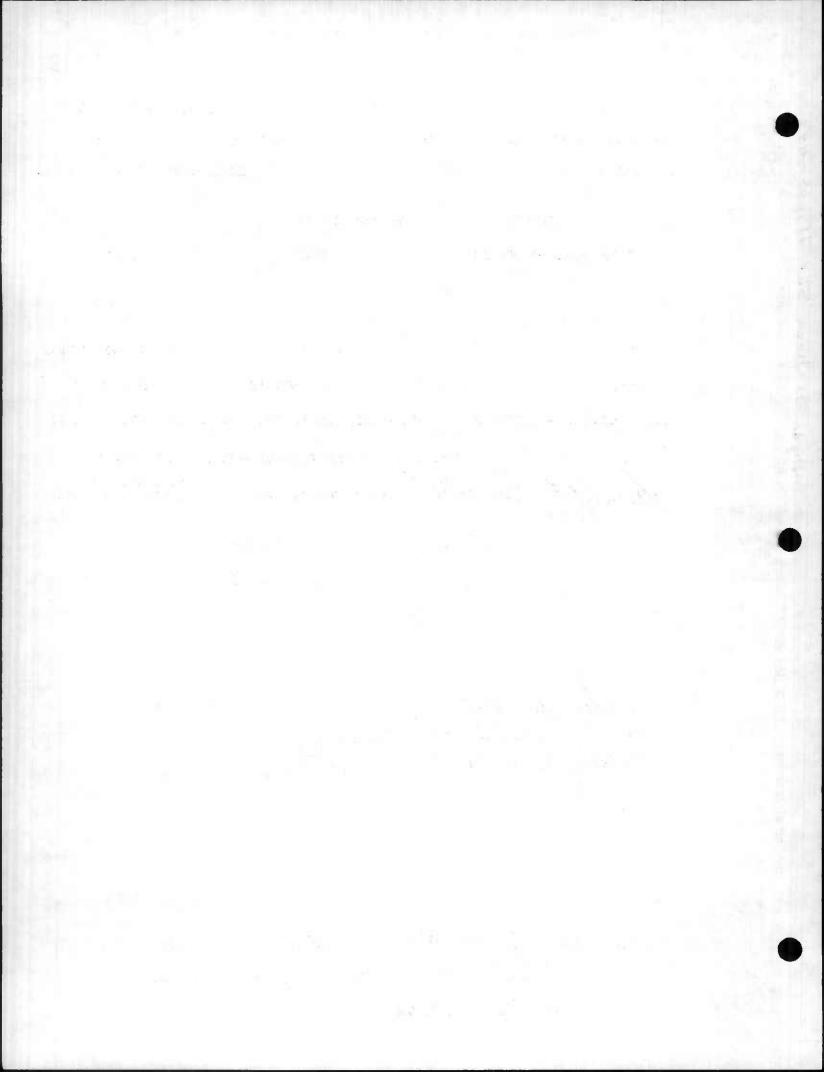
al Davidson Rardall

JAN 091998

Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Vear Nannie Gayle January 3, 1998 /Medical 7:40 AM 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner s. last birthday) Salisbury, If Under 24 Hrs. Salisbury Center: Genesis ElderCare Wicomico If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be notified at Yes 2 No Director 10g. Citizen of What Country? ò "natural", or items 23a Funeral 12. Was Decedent Ever in U,S.
Armed Force

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 by 3 Widowed 4 □ Divorced Completed 16e. Dacedant's Usual Occupation
(Give kind of work done during most of working life, po NOT usa rayred)

Scauti Lian 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seçopdary (0-12) Collage (1-4or 5+) HAIR DRESHER 17. Fathar's Name (First, Middle Last) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, 20b. Place of Disposition (Name of Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ST5/2 31Value 23e. Pert1. Enter the disease, or complete from that caused the death. Do not enter the mode of dying, such as shock, or heart failura. List only one cause on each line. Physician ARIAN CANCE /Medical Immediete Cause (Final disease or condition rasulting in daath) years Examiner Due to (or as a consequence of): Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequenca of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): the ettending for use es Part II. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed t Records, Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

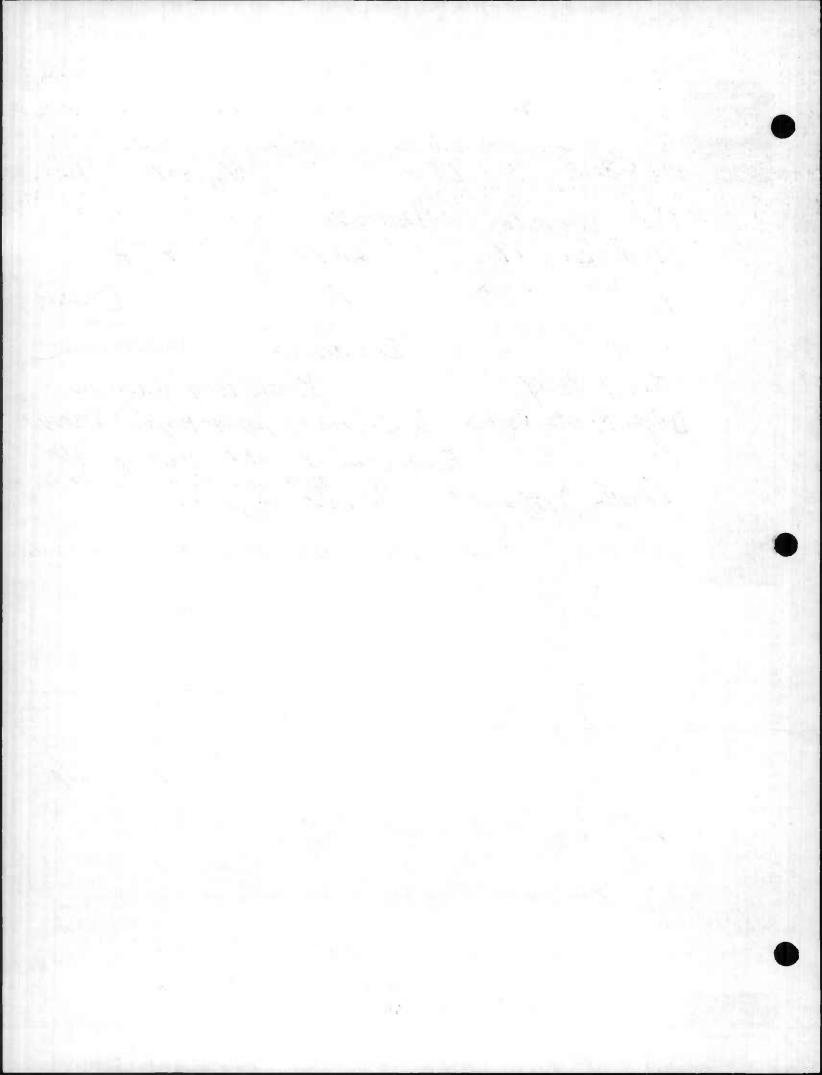
To the Funeral Director: Affer this certifica completely filled in by the funeral director, t 25. Was case referred to medical examinar? 26. Place of Death (Chack only ona) Hospital: Othar: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Panding Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homloide Certifying Phyalcien: To the best of my knowledge, death occurred et the time, date and placa, end due to the ceusa(s) and manner as stated. 29a. Cartifier Medical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred et the time, date end placa, and due to the causa(s) end manner statad. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w

complated causa of death (Itam 23a) (Type, Print)

Pagistrars Signature

1104 Healthway Dr., Salisbury, MD 21804

State Registrar 31. Date filed (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 5 Certificate of Death #24a per Phy G756 2/12/98 EW

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death NANCY Month 20:47 MANUARY 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Randallstown Baltimore Northwest Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 53 Yrs. Birthplece (State or Foreign Country) 1 M 2 X F 217 44 8764 Yrs. 1944 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6655 Sykesville Road 21784 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4√ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) draftsperson art 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas V. Taylor Dorothy Dean Crowe 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Diana Batson (sister) 1108 Neptune Place Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, cremetory or other plece)
Gates of Heaven Cemetery 1-8-98 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Silver Spring, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195Sykesville, Md. 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth SEPTICE MIA | SEPTIC SHOCK

Due to (or es e consequence of):

JAUNDICE | LIVER FAILURE

Due to (or es e consequence of): Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest CHOLESTATIC Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? INSIPIDUS. 1 Yes 2 No 26. Piece of Deeth (Check only one) Hospitel: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No

The law requires that the death certificata be executed P.O. Box 68760, Division of Vital Records, certificate Attending Physicien: this in by the funeral After deeth.

Physician

/Medical

Examiner

Md

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "neturel", or items 23e or 28s-f show traumatic event, the Medical Examinar must be notified at

other 1

Depertment of important: If eny injury or

Physician

/Medical

Examiner

Physician/Medical Examiner

Be Completed

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Certification:

Medical

Director

or A

Hospital To the Hospital within 24 hours a To the Funeral Complataly filled

Pages 1 end 2 should be filed within 72 hours efter nent of Haalth and Mantal Hygiane. Int: If Item 27 is marked other than "neturel", or ite

I Hygiane.

death with the Maryland

21215-0020

Baltimore, Maryland

Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. WARETES MELLITIS EMPTY SELLA SYNDROME DABETES

25. Wes cese referred to medical examiner? 1 Yes 2000

2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year)

29b. Signature end title of certifier MD

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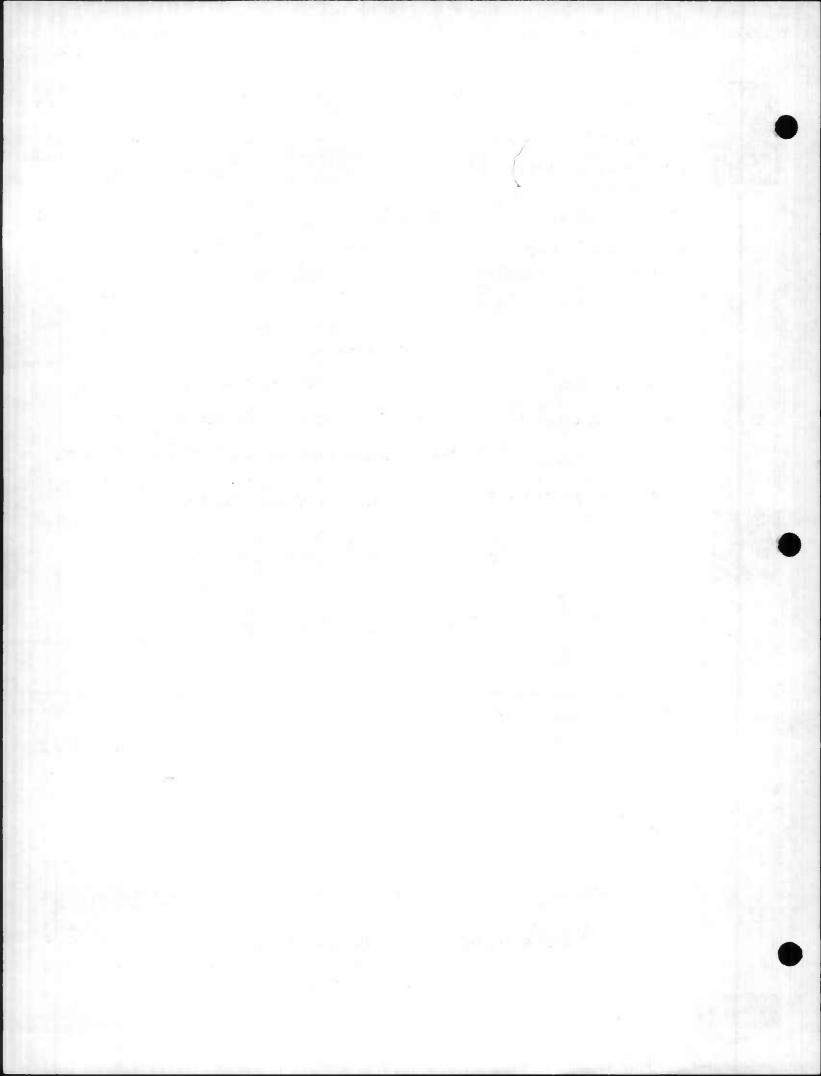
JANUARY 4 1998

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) THO MUSCLEDRAE, KOLIMINEST HISPITAL CENTER 5401 OLD COURT ROAD, RANDAUSTOWN

State Registrar 31. Date filed (Month, Day, Year)

JAN 09 1998

32. Registrer's Signeture Dia d'accison Revall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 1, William Thomas HARTILL, JR. 5:15 PM 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Glade Valley Nursing and Rehabiltation Ctr. Walkersville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Sept. 29, 1907 Frederick 5. Social Security Number 6. Sex 1 M 2 □ F 9. Birthpiace (State or Foreign Onlo) 317-09-8736 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Indiana St. Joseph Michigan City 1 X Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 212 Eddy Street, Apt. 104 46360 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 240 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3XWidowed 4 Divorcad 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Foreman Steel Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas HARTILL, SR. Nell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cathy Boyd, Daughter 108 Copper Oaks Court, Woodsboro, Maryland 21798 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 NOther (Specify) Entembrent Resthaven Memorial Gardens, Jan. 3, 1998 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approxim Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3. Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

7 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Mexical Examiner must be notified at

deeth with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumants.

the buriel-tran s cermicate has been signed by director, page 2 should be detact After this certificate funeral

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Hospital or Attending Physician:

To the Hospital of within 24 hours e To the Funeral D

Examiner Physician/Medical à Completed Be Medical Certification: To efter death. filled in by the

25. Was case referred to medical 1 Yes 2 No

27. Menner of Death 5 Pending investigation 1. Natural 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

and address of person who completed cause of death (Item 23a) (Type, Print

28b. Time of

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year) January 2, 1998

FRED MD 21702

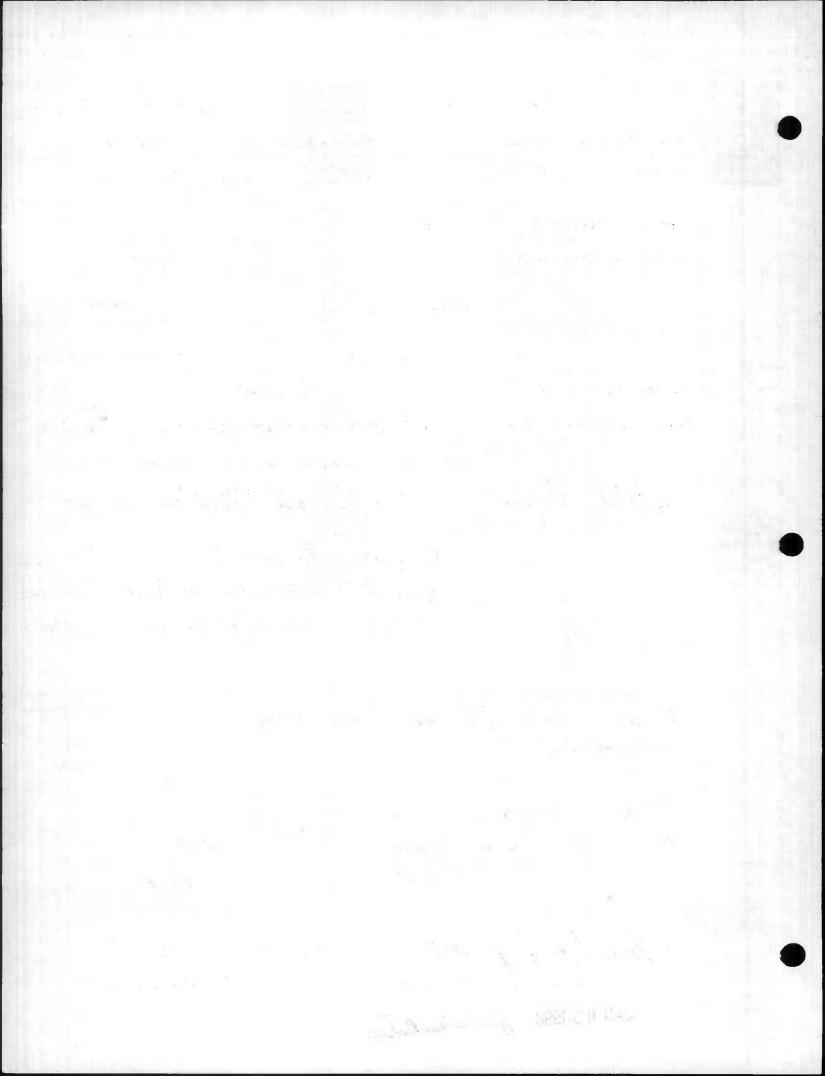
State Registrar



LAN CO MAL

State of Maryland / Department of Health and Mental Hygiene

					Cen	tificate o		worka, rry	Reg. No.	0	1/13
Physici		Decedent's Neme (First, Middle, La Norman Car	ist) 1ton	Hammond	ì			2. Dete of De Month Januar	eth Dey	Yeer Q.8	3. Time of Death 1:30 p.m
/Medic Examir		4e. Fecility Neme (If not institution, gir Frederick Memori					4b. City, Town, o	r Location of Deett	4c. County		
Funeral Director			Sex 7. 1⊠M 2□F	Age (In yrs. lest	birthday) Yrs.	If Under 1 Yes Months Dey			th y, Year)	9. Birthp	olece (State or Foreign ntry) ine
r 28a-f show	ector	10a. State 10b. County Maryland Freder 10e. Street end Number	ick	Mt. A					10g Citizon of 1		0d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with	Funeral Directo	106. Street end Number 10f. Zip Code 803 Rising Ridge Court 21771							United	of What Country?	
5 2 2	b	11. Maritel Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decede Armed Force 1 [X] Yes 2 [If Yes, Give Year or Date	s? ⊒ No		/es Decedent or Yes, specify Cu ☐ Yes 2 🖾 N	f Hispanic Origin? (lben, Mexicen, Pue o <i>Specify:</i>	(Specify Yes or No erto Rican, etc.)	- 14. Rac Blac Specify	ck, White,	
within ane.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)			(Give k	ent's Usuel Occ ind of work don O NOT use reti	upetion le during most of w red)	orking	16b. Kind of B		
of a should be filed v the and Mental Hygie 7 is marked other traumatic event, in	To Be Co	17. Fether's Name (First, Middle, Last Carlton H. Hammo:		110	mager	18. Mother's Na	ame (First, Middle, Keller		siness Machir ^{meme)}		
s 1 en f Heal f Heal		Jeanne S. Hammond 20e. Method of Disposition 1 ☑ Buriel 2 □ Cremation 3 □	/ Wife	20b. Place ceme	803 R of Dispos stery, crem	Rising I ition (Neme of etory or other p		rt, Mt.	Airy, Ma 20c. Location -	aryla City or To	nd 21771 own, State
permit. Pages 1 a Department of Hee Important: If Item any injury or othe		4 Donetion 5 Other (Speci	**	Arlin	01	Name end Add	al Cemete loss of Fecility Moleswort lge Road,	h Funera	1 Home		Virginia 20872
The lew requires that the death certificete be executed The lew requires that the death certificete be executed The lew requires that the effection physician end page 2 should be detected for use as the buriel-trensit	Physician/Medical Examiner	23a. Pent1. Enler the disease, or con shock, or heart failure. List only Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury theil initiated events resulting in death) Lest	e b d		e consequential	oxic sence of): cular 7 sence of): vular				57	Approximate Interval Between Onset and Deeth 3 days 3 days
ires that the death cersigned by the ettending be deteched for use	by Physician	Pert II. Other eignificant conditions of	rtery				given In Pert I.	40	tobacco uee co		o the cause of death? bebly 4 Unknown
The lew require	Completed	Preumonia	· .				+	24a. Wes perfo	an eutopsy med?	co of	ere eutopsy findings eileble prior to mpletion of ceuse deeth? //A
To the Hospital or Attending Physician: The lew requires the within 24 hours efter death. To the Funeral Director: After this certificate hes been signe completely filled in by the funeral director, page 2 should be a	Certification: To Be (25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Pending Investigation 3 Suicide 6 Could not be	28e. Dete of Ir (Month, I	ospitel: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			N	dence 6 Oth	□Other (Specify) occurred		
spital or A nours efter heral Dire		4 Homicide determined	time, dete end plea	28f. Location (Street and Number or Rurel Route Number City or Town, State) Ce, and due to the cause(s) and menner as stated.			tated				
To the Hospital or Attending within 24 hours elter death To the Funeral Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Example one) Medical Example one of the operation of the operati	of examinetion stated.	oge, dearn occurred et the time, dete end piece, end du n'end/or Investigation, in my opinion, deeth occurred et t				d due fo the ceuse(s) end menner es stated. et the time, date end place, end due fo the cause(s) 29d. Date signed (Month, Dey, Year)			
Sta Registr	ar	30. Name end eddress of person who Michael W. Lei 31. Date filed (Month, Dey, Year) JAN 0 5 19	angie, M	death (Item 23e 1D 3 (D strar's Signature	w.	7th St	· Fred	lerick, i	mD z	1701	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8, 1998 MATTIE Elizabeth

4a. Fecility Name (If not institution, dive streat a MATTIE HUSTED 6:55AM Jan. /Medical end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Center; Genesis Eldercare
5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Salisbury,
r | If Under 24 Hrs. |
| Hours | Min. | Wicomico Md. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (Stete or Foreign Country) Days 1□ M 2□ F 206-12-2975 Usual Residence of Decedent 04 13 Williamsburg PA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1₽ Yes 2□ No Director Wicomico MD Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31685 Hideaway Drive
12. Was Decedent Ever In U.S. Armed Forces? Funeral 21849

13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Hace - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify: þ Specify 3√ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None-Housewife 18. Mother's Name (First, Middle, Maiden Sumeme) Housewife 17. Father's Name (First, Middle, Last) Be 2 Charles Hutchins Alice Sterling Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Steven Allan Husted/Son 20b. Place of Disposition (Name of cemetery, cremetory or other place)

31685 Hideaway Drive, Parsonsburg, MD 21849
20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removel from State Shad Point Cemetery 1/12/98 Salisbury, MD 22. Name end Address of Facility Holloway Funeral Home, P.A. 501 Snow Hill Road, Salisbury, MD the death. No not enter the mode of dying, such as cerdiac or respiratory arrest, the cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) les Due to (or as a consequence of): Examiner prof Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of ceuse of death? Completed 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural

burial-transit and physician s the burial Box 68760 attending 0 Division of Vital Records, P.O. the signed by t Deen has certificate To the Hospital or Attending Physician: Aftar this funeral

Physician

/Medical

Examiner

Funeral

Director

? is merked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural", or than any injury or other traumatic.

Baltimore, Maryland 21215-0020

the Maryland

Certification: To

24 hours after death. within 2 To the

State Registrar

Medical

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖰 certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier 29c. License number

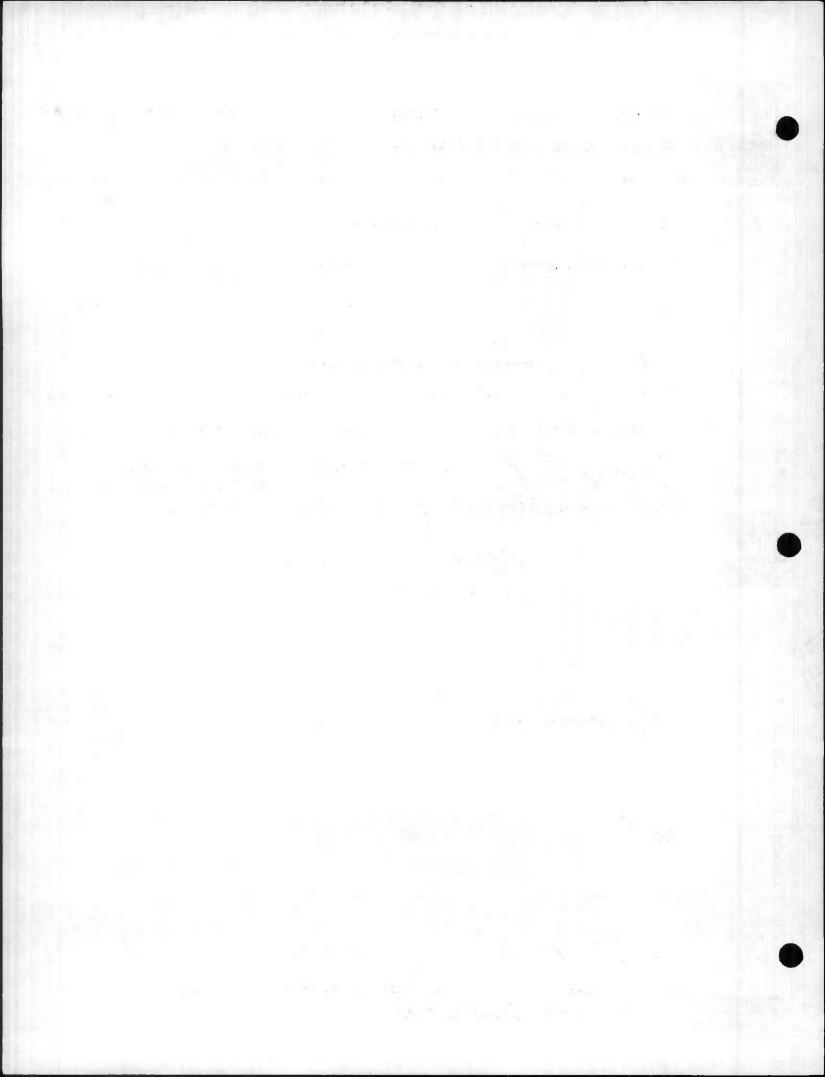
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Dey, Yeer)

1104HEALTHWAY DR., SALISBURY, MD. 21804 Registrar's Signature

31. Date filed (Month, Day, Yeer) JAN 091998

William Robins



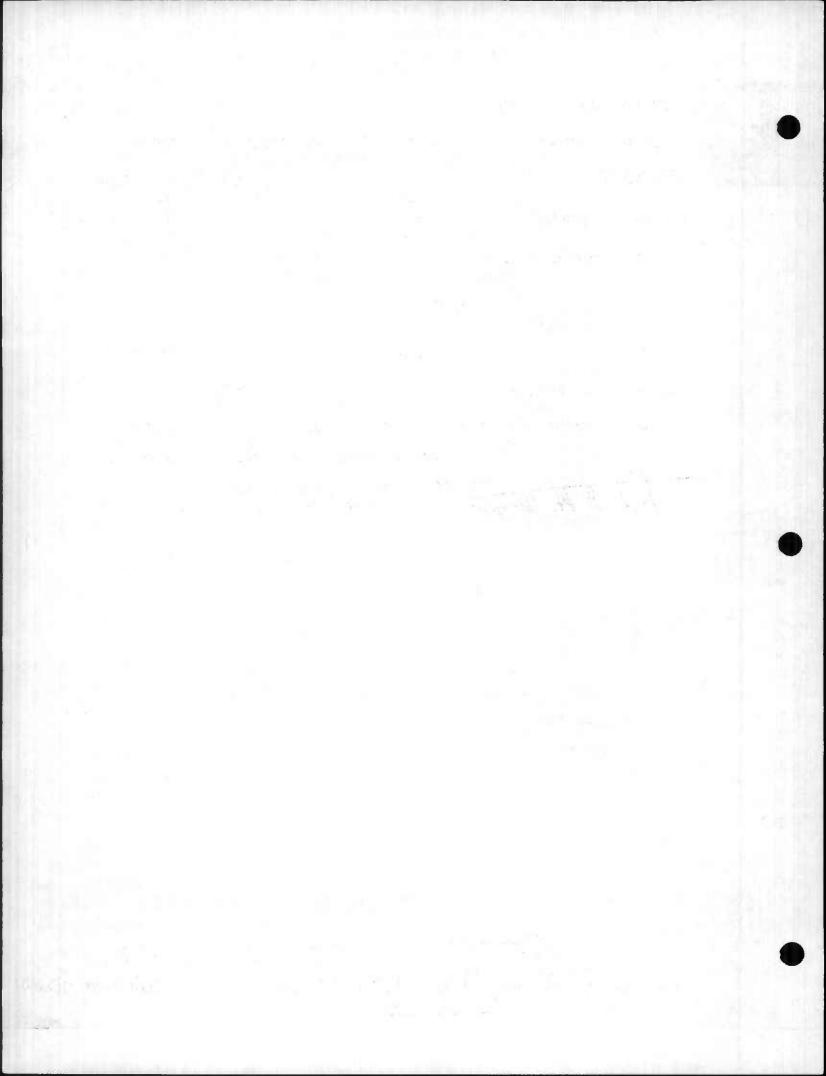
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month GEORGE WASHINGTON HAMILTON 01 04 1998 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER-GENESIS ELDER CARE SALTSBURY COMMODIW If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Undar 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F Vrs Director 186-09-7541 4/16/12 Virginia Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avent, the Medical Examiner must be notified at Maryland Wicomico Director Salisbury 1 ¥Yes 2 □ No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 0 705 College Lane, Apt. 2 or Itams 23a 21804 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 ⊠ Yes 2 □ No If Yes, Giva Yaar or Dates: WW II 1 ☐ Never Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: White 3 ₩ Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry oe filed within 7 ial Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) U.S.D.A. Inspector 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surneme) Be Pages 1 and 2 should be from all Health and Mantal I James Pearl Hamilton Amanda Julia Jones 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health or Important: If hem 27 is any injury or other trau 30702 Gordy Mill Rd., Delmar, MD 21875
Date 20c. Location - City or Town, Stete Sandra H. Christman/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 1 Burial 2 □ Cramation 3 □ Removel from State Wicomico Memorial Park 1/7/98 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury, MD and Ameral Service Licenses 22. Name end Addrass of Facility M01051 Holloway Funeral Home 23a. Part 1. Enter the disease, or complications the caused the death. Do not anter the mode of dying, such es cardiec or respiretory errest,

App. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immadiate Cause (Finel diseese or condition resulting in death) Examiner Examiner be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest physician and the buriel-tran Due to or as e consequence of P.O. Box 68760, Physician/Medical the Due to (or es e consequance of) Pert II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, Àq 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? Completed 2 No Division of Vital septal or Attending Physician: hours after death.
Ineral Diractor: After this certificaty filled in by the funeral director; 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: ✓ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 1 Naturel 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No 8 Could not ba 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) To the Hospital or within 24 hours aft To the Funeral Dir completaly filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1104 Healthway Dr. Salisbury MDa1804 State

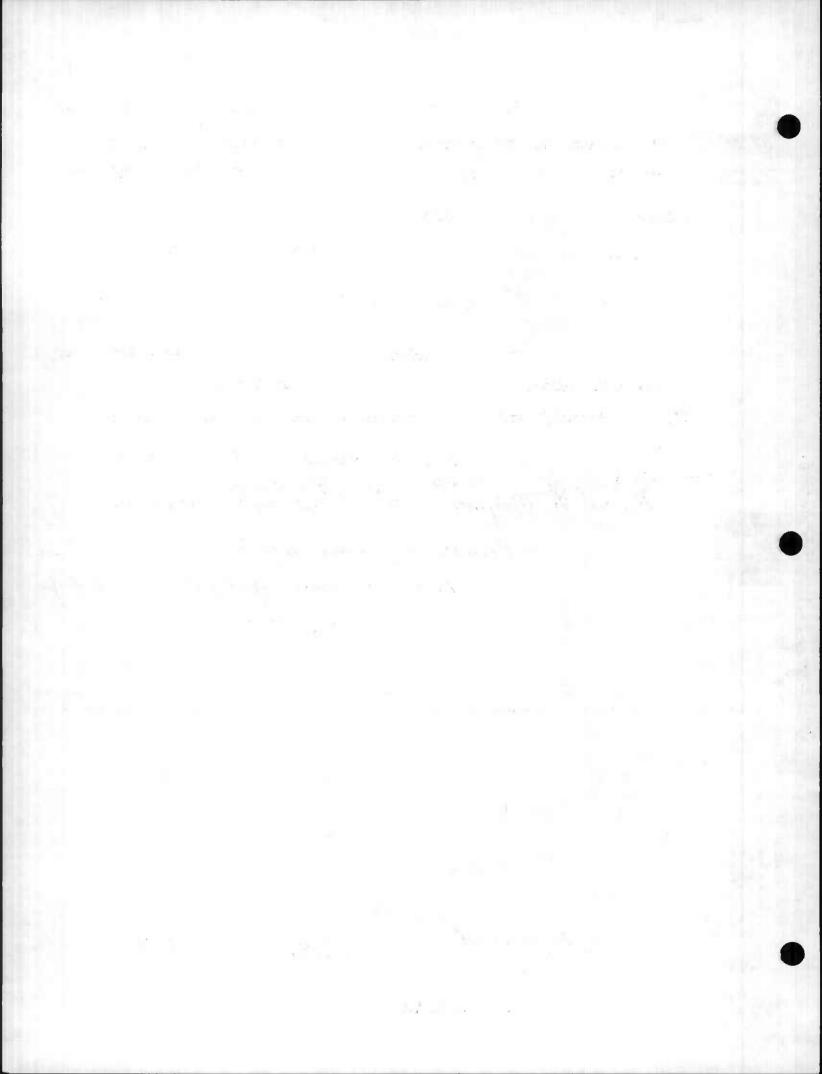
Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Physician F. JACKSON ROBERT Januar /Medical 4a. Fecility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Deets 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Date of Birth (Month, Day, Ye 11/28/30 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Min 125M 2□ F Months Deys Hours 222-16-9431 Director 67 Delaware Usual Residence of Dacadent filed within 72 hours after death with the Maryland 10e Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Sussex Milton 1 Yes 2 No Director Delaware 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 19968 USA 403 S. Lake Dr. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: White p 3 Widowed 4 Divorced Year or Dates: Korea "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automobile Dealer Driver other traumatic event, Baltimore, Maryland 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Pages 1 end 2 should be Robert C. Jackson Mary Conway 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) interest of Heelth a Elaine J. Barnett/Daughter 1019 Union Church Rd., Elkton, MD 21921 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or othar plece) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State ö Delaware Vet. Memorial Cemetery 1/13/98 Bear, DE 5 Other (Specify) 4 Donati eral Service License 22. Name and Address of Facility M01051 Holloway Funeral Home (Dompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on lech line. Approximete Intervel Between Onset end Death **Physician** Probable /Medical Mys cardeal Immediate Causa (Final diseasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest the bunel-tren The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760. ettending physician for use es the bune 0 Physician/Medical Due to (or as a consequence of): ate hes been signed by the e pege 2 should be detached t Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Rhoumatord arthretis ubus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were eutopsy findings availabla prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA 2 1 Yes 2 No this funeral 27. Menner of Deeth Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Naturel 2 Accidant 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No 6 Could not be datermined 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 18 30. Name end eddress of person who com Aganval 614C Castern 31. Date filed (Month, Day, Year) JAN () 9 1998 22. Registrar's Signature State Registrar

Robert Jackson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 0 1 7 1 7

					C	ertifica	ate of l	Death		Reg. No.	0	1 1 1
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Examiner "Funeral Director	5	e. Fecility Name (If not institut DORCHEST) . Sociel Security Number 220-01-8827	_	number) UERA 7. Age (In yr. 85		Month	AL (der 1 Year	b. City, Town, or QMbV1 If Under 24 Hrs Hours Min.	dge	Dor	ches	eco (State or Fo
with the Maryland a or 28a-f show be notified at	1	Jsual Residence of Decedent Oa. State 10b. Coun MD Do	rchester	10c. 0	City, Town o		nbridg	e			10	0d. Inside City Li
th with the Mar 23a or 28a-f sl		0e. Street and Number 1 Maple	Ave.			10f. i	Zip Code	21613		10g. Citizen of W		try?
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ould be filed Mental Hyg arked other atic event,		7. Father's Name (First, Middle Thomas	Everet	t J	ones					Malden Surname ewberry	9)	
end 2 shou salth end lv 127 is mar er traumet		9a. Informant's Name/Relation Mrs. Jane S.		ife				and Number or Ri Cambric		er, City or Town, S	State, Zip	Code)
nit. Peges 1 e artment of Hei ortent: If Item injury or othe	2	0a. Method of Disposition 12 Burial 2 □ Cremation 4 □ Donation 5 □ Other		n State		crematory o	r other plac	yard 1	Date 17-98	20c. Location - C		
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certificate hes irector, page 2 Be Comp		5. Was case referred to medic	al					00 81 (8	10		1 🗆	Yes 200 No
To the hours after death, within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pend 2 Accident	Hospital: 1 28a. Date (Moi tigetion	Inpatient 2[e of Injury nth, Day Year)	□ ER/Outpat 28b. Time Injur	of	28c. Injury Work	r: 4□ Nursing H		dence 6 Othe)
prist or Arenging Provise from the filled in by the tuners if filled in by the tuners if Certification:	-	4 Homiciae	mined 286. Place	e of Injury - At I	eity)				City or Tov			
within 24 hours within 24 hours completely filled		9a. Certifier (Check only one) 2 Medica 9b. Signature and title of certifier		e best of my kn basis of examin nner stated.	ation and/or	Investigation	on, In my op	inlon, death occu	rred at the time,	date end place, a	(Month C	the cause(s)
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	-		who completed cau		- 00 1 -							2.16

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth AMANDA, KNight EDITH 2:45 AM January 98 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Westminster C Hunder 1 Year Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) County General Haspital Carroll County Carroll 7. Age (In yrs. lest birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) 1 M 20 F 71 Yrs 213-46-4023 3/25/1926 MARYLAND Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits CARROLL FINKSBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 913 LORRAINE DR. 21048 USA. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Yeer or Detes: 14. Rece - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) FACTORY WORKER MANUFACTURING 6 18. Mother's Neme (First, Middle, Maidan Sumame) 17. Fether's Neme (First, Middle, Last) GEORGE CLEVELAND KNIGHT MYRTLE GREEN 19b. Mailing Address (Straat and Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. fnforment's Neme/Reletionship (Type, Print) KENNETH KNIGHT -BROTHER 913 LORRAINE DR., FINKSBURG, MD. 21048 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State CARROLLTON CHURCH OF GOD 1/12/98 FINKSBURG, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility FLETCHER FUNERAL HOME 21. Signature of Surprial Service Licens 254 E. MAIN ST., WESTMINSTER, MD. 21157 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each me. Approximete Intervel Between Onset end Death Immediete Ceuse (Final diseese or condition resulting in deeth) 10 Days Bue to (or es e consequenca of): Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that i Due to (or es e consaguence of): that initieted events resulting in death) Lest Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown ailure 24b. Ware eutopsy findings eveileble prior to completion of cause of daeth? 24a. Was an eutopsy 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD.

Director

Funeral

by

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Director

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7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner result be a

Pages 1 and 2 should be filed within 72 hours after death want of Health and Mental Hyglene.

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Baltimore, Maryland 21215-0020

the Maryland

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page 2 certificate this funaral daath. after daati filled in by

Division of Vital Records, P.O. Box 68760,

or Attending

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To the Hosp within 24 hor To the Fune completely fi

Examiner Physician/Medicai þ Completed Be

25. Wes case referred to medical examinar?

2 Certification:

Medical

Registrar

1□ Yes 2 No

27. Manner of Death Natural 5 Panding 2 Accidant 3 Suicide

4 Homicida

(Check only one)

29b. Signeture end title of cartifier

29a. Certifier

6 Could not be datermined

28e. Dete of Injury (Month, Dey Year) Investigation

28b. Time of

1 Sippatient 2 ER/Outpetient 3 DOA

28e. Place of Injury - At homa, ferm, street, factory, office building, atc. (Spacify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

29c. License number

1 Certifying Phyeicfen: To the best of my knowledge, death occurred et the time, data and place, end due to the causa(s) and mannar as stated.

2 Medicaf Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) end menner stated.

26. Piece of Deeth (Check only ona)

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Yeer)

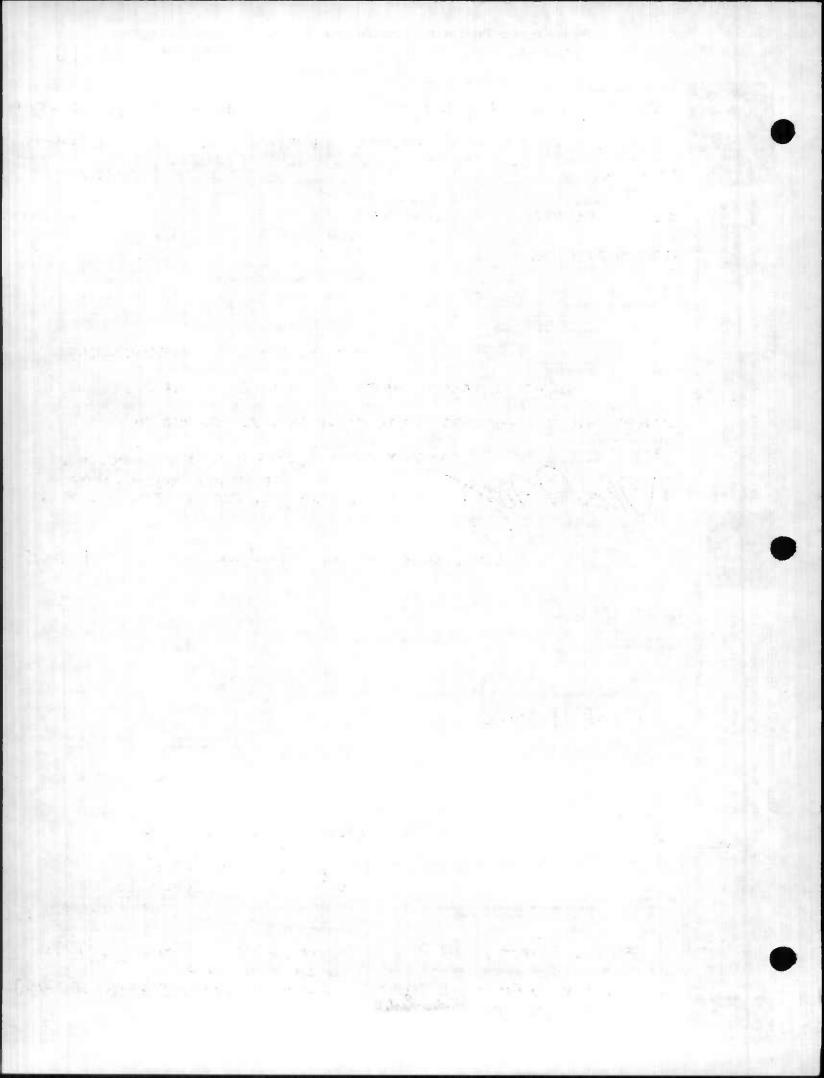
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

M.D. 30. Neme end eddress of person who completed cause of deeth (Itam 23e) (Type, Print)

00052419 LISA KIM, M.D

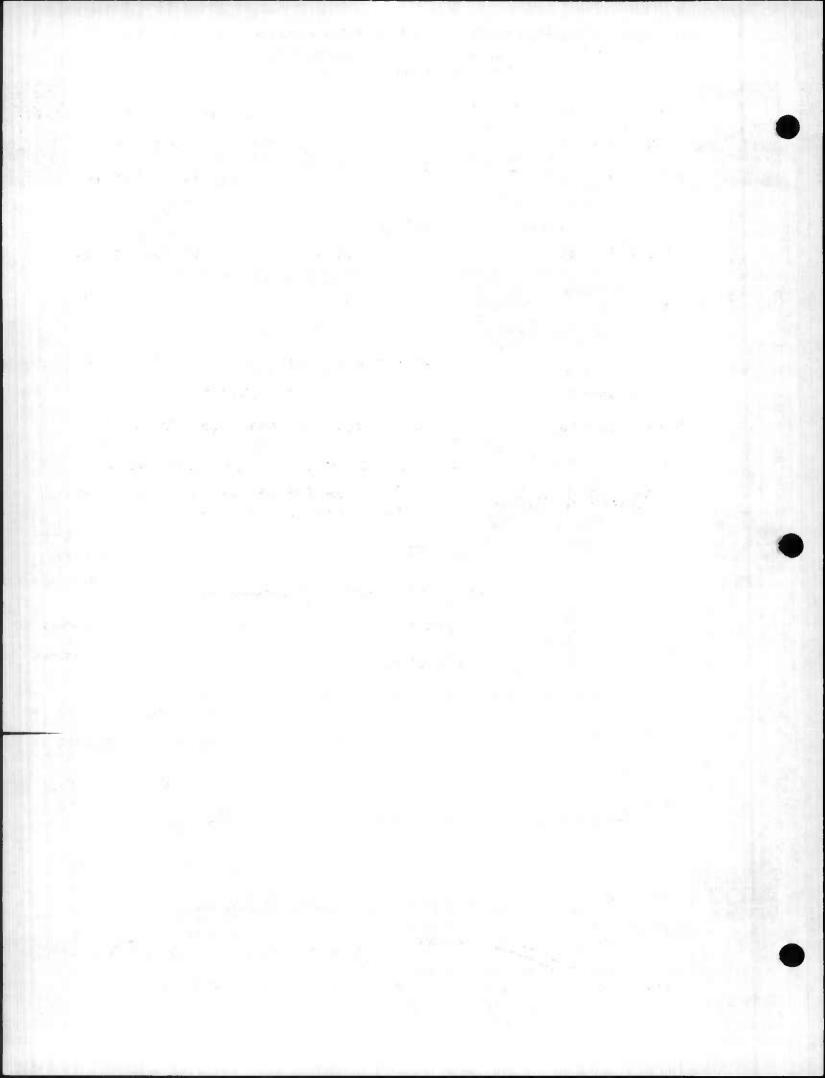
Hospital, 200 memorial Ave, WestMinster, MD 21157 County General

32. Registra Signature



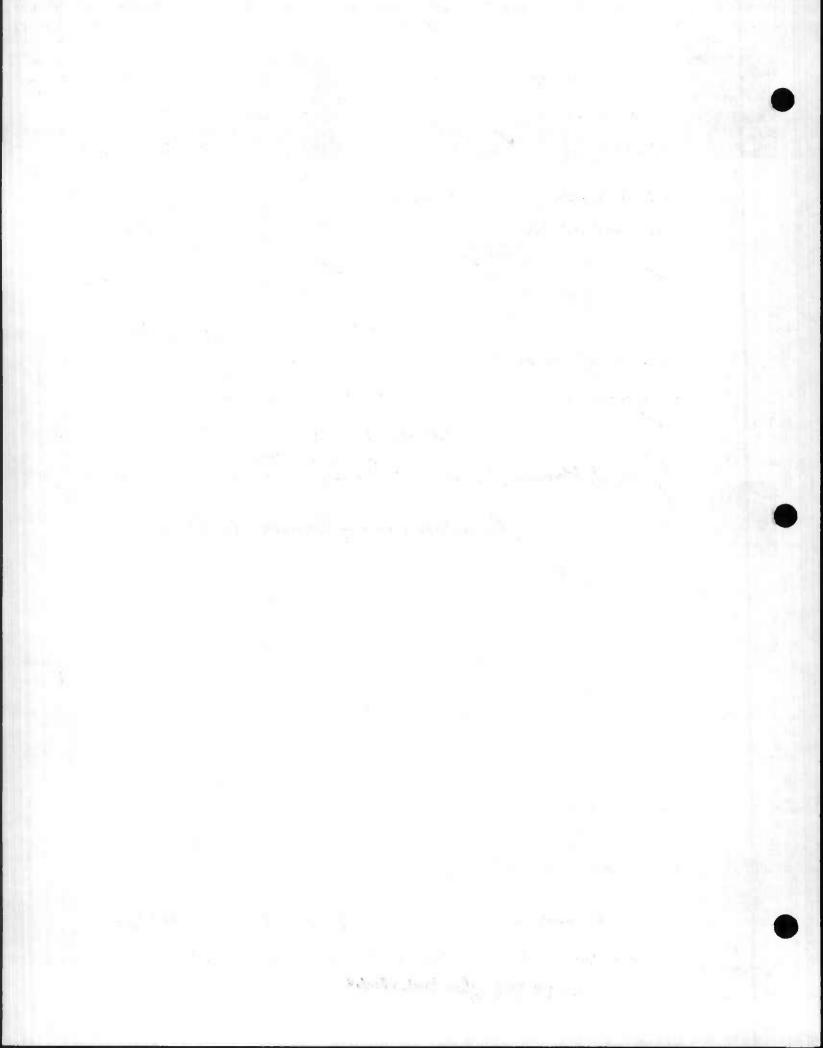
State of Maryland / Department of Health and Mental Hygiene

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		30. Nama and address of person who Ahmed Nawaz,					Cam	bridg	e, MD	21613		
Sta	te	31. Data filed (Month, Day, Year)			or Rand							



State of Maryland / Department of Health and Mental Hygiene 8 0 1 7 2 0

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Physician (Medical Examiner) The disease or completation stress complete constraints and stress complete constraints comp	9	a H	Be	17. Fether's Name (First, Middle, La	st)					18. Mothe	er's Name	e (First, Middle,	Maiden Sumai	ne)		
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Physician (Medical Examiner) The disease or completation stress complete constraints and stress complete constraints comp	sho	Pue		19e. Informent's Name/Relationship	(Type, Print)		19b. Meilii	ng Address	s (Street	end Numb	er or Rure	el Route Numbe	or, City or Town	Stete, Zip	Code)	
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Physician (Medical Examiner) The disease or complication stress complexion in the disease or complexion is the course of dark immediate Cause (Final disease) or complexion immediate Cause (Final disease) or conficient resulting in death) Due to (or es e consequence of): 24e. Wes an eutopsy performed? 25e. Place of Deeth (Check only one) 25e. Place of Deeth (Check only one) 25e. Wes an eutopsy performed? 26e. Place of Deeth (Check only one) 27e. Monthson Cause (Check only one) 28e. Dute to hypy year) 28e. Dute to	seg	or F		1 Deurial 2 □ Cremation 3						,						
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Physician (Medical Examiner) 22	E E	por y in		21. Signature of Funeral Service Lic	ensee		22	. Name er	nd Addre	ess of Fecili	lla					
28. Effect of the first of Barrian Sequence of Sequenc	2	9 = 9 9		1 211	. 0	40000									44.4	04056
Physician // (Activing Processor) from the final content of the course of each line. Personal content of the course of the co		-		Janes J. Pu	mon h-	MUUZS	5 1	16/3	Some	erset	Aver	iue, Pri	incess /	Anne,		
Physician (Madical Examiner Ex				hock, or heert feilure. List on	mplications that cause ly one cause on eech I	d the death. ine.	Do not ent	er the mod	e or ayı	ng, such es	cerdiac	or respiretory er	rest,		Intervel f	nete Between
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The state of the s	fice	A Se	8	resulting in death) Lest		200 (0 (0.	00 0 00,1004	1001100 01/1						į		
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Part I. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably Unknow	athe	for L	Jar													
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24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 Yes 2 No	at th	by	Ph									10	res 2□ No	3 Prof	bably 4	Unknow
24a. Wes en eutopsy prindings performed? 24a. Wes en eutopsy findings performed? 1 Yes 2 No Yes	es th	o e			-											•
25. Wes case referred to medical examiner? 1 Yes 2 No 1 Yes	e in	n sig										24a. Wes	en eutopsy	24b. W	ere eutop:	sy findings
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26. Place of Deeth (Check only one) 26. Place of Deeth (Check only one) 27. Manner of Death 16. Naturel 28. Describe how Injury occurred 28. Licelian 28. Describe how Injury occurred 28. Describe how Inj		pag	Ö									1 🗆 Y	es 2XNo	10	∃Yes 2	P No
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C. Huddleston M.D. 103 Milford Street, Salisbury, Md. 21804				///					V	7/0	<u>ب</u>		-1/	10		
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State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture					on M.D. 1	03 Mi	llford	Stre	eet,	Salis	sbury	y, Md. a	21804			
Registrar INN 1 2 1998 Sulin Buulion Rodak		Sta	ate		32. Regist	rer's Signet	ure .	P.								

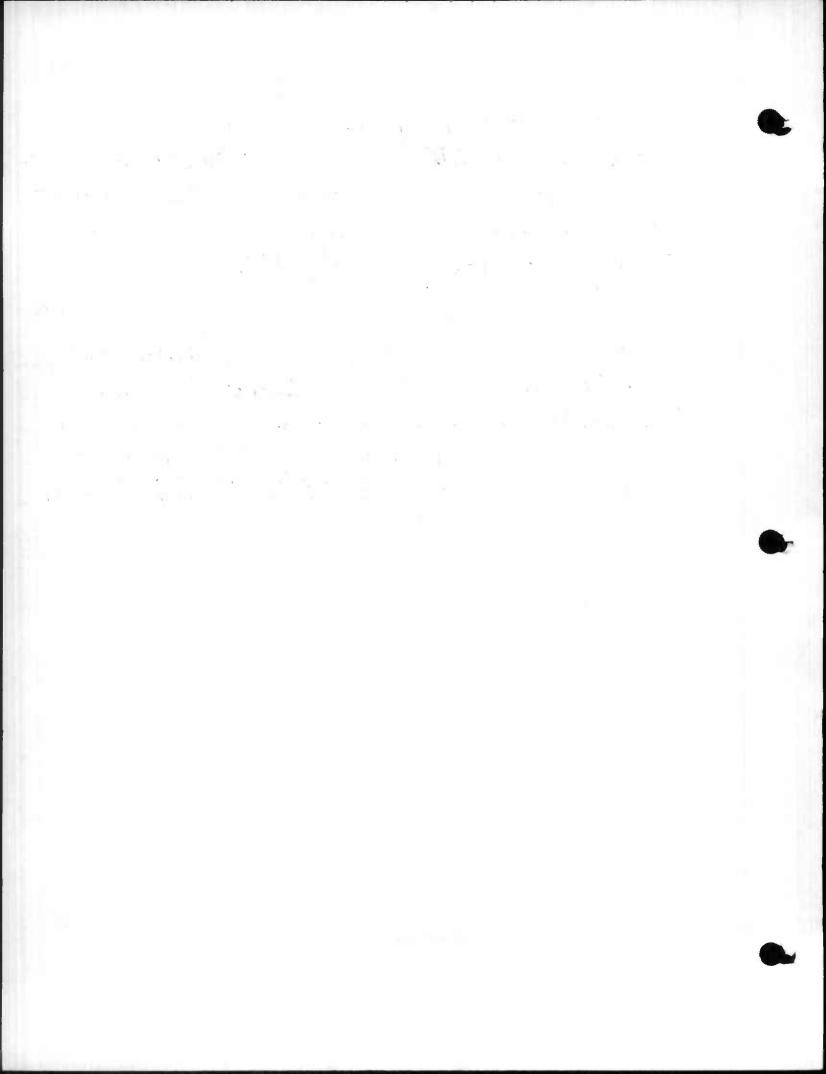


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT (ERTIFICATE		MENTAL HYGIEI		01/61
	1. DECEDENT'S NAME (First, Middle, Lase)	NENdolun	11.1 0		2. DATE OF DEATH MONTH	ex o a	3. TIME OF DEATH
		S. SEX 6. AGE (In yrs. las	st birthday) IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8 48	BIRTHPLACE (State or Foreign
	010 39 0113	1 DM 2 DKF 70		AYS HOURS MIN.	0 - 27 -		SALE: 96 N.C.
E C	5. FACILITY NAME (It not institution, give street 5. Somets Cove Add	et end number)	96. CM Y	OWN OR LOCATION OF E	EATH	9c. COUNTY	ON DEATH J
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100 COUNTY	0.	10c, SITY, TOWN OR	OCATION .			Omenser
	MD Son	neiset	CIIST	100			10d, INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	5 Jomes Co	ic Apt.		101. ZIP CODE	17	10g. CITIZEN	OF WHAT COUNTRY?
N S	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 A		DECENDENT OF HISPA	NIC ORIGIN? (Specify Years, Puerto Bican, etc.)	s or No — 14.	RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		YES 2 NO Speci			Specify: Black
TED	15. DECEDENT'S EDUCA' (Specify only highest grade co	mpleted) (G	CEDENT'S USUAL OCCU	IPATION ng most of working	15b KIND OF BU	SINESS/INDUST	HY 1
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	House	wife.	Pa	Vate.	Home
	17. FATHER'S NAME (First, Middle, Last)		70 300 0	16. MOTHER'S N.	AME (First, Middle, Meide	Surname)	73
BE	19a. INFORMANT'S NAME (Type/Print)		b. MAJLING ADDRESS (S	treet and Number of Burel	Acusto Number City or En	vaha	<u></u>
2	Coma Miles Fi	Husband 5	Lomeis C	ove Apt. (Cristicle	1, Mi	21817
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)		AND DATE OF DISPOSITION (Investory of other place)	101.0	1-13-98 L	CATION - City	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN			- 1	CILITY I	MENCE	1, 1010
	1 Hally	-ward	1 314	Cove SI	Vala + UIS	ald 1	10 21817
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	mplications that caused the de at only one cause on each line	ath. Do not enter the	mode of dying, suc	ch as cardiac or reap	iratory arrest	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition	Melastatic	Moon	Lunberry	in atio	/11	Onset and Death
	reaulting in death) s.	DUE TO (OR AS A CONSEC	DUENCE OF):	(Mario	in end	ogy	DIX MONTHS
NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	QUENCE OF):			. /	
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury						
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF);				
	PART II. Other significant conditions	Contributing to death but not r	aculting in the unde	dulas acus alum la	D-A/ Law amaza		
CAL		on a board but not r	esolung in the under	rlying cause given in	Part i. 24a. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						2 DAIO	OF OEATH?
z	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL				N 🗆		
1 9 1	I SE TOUS CASE HEI ENNEO TO MEDICAL	IOSPITAL:	OTHER:	Home 5 Residence	6 (1 Other (Specify)		
SICIA			DOA A Nursing				
PHYSICIA	1 U YES 2 D NO 1	□ Inpatient 2 □ ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Year)		: INJURY AT	28d. OESCRIBE HOW	INJURY OCCUR	:0
BY PHYSICIAN:	1 UPS 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Morith, Day, Year)	28b. TIME OF INJURY M 1	WORK?			
B⊀	1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending	☐ Inpatient 2 ☐ ER/Outpatient 3 28e. DATE OF INJURY	28b. TIME OF INJURY M 1	WORK?	28d. OESCRIBE HOW 281. LOCATION (Street City or Town, Stele	end Number or R	
B⊀	1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	□ Inpetient 2 □ ER/Outpetient 3 28e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY — At ho	28b. TIME OF INJURY M 1	- INJURY AT WORK? YES 2 NO office	281. LOCATION (Street City or Town, State	end Number or R	
B⊀	1	□ Inpetient 2 □ ER/Outpetient 3 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At hobuilding, atc. (Specify)	28b. TIME OF INJURY M 1 me, farm, street, factory, ath occurred at the time,	INJURY AT WORK? YES 2 NO office	281. LOCATION (Street City or Town, Stete	end Number or R	ural Route Number,
	1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	□ Inpetient 2 □ ER/Outpetient 3 28e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY — At hobuilding, atc. (Specify) IN: To the best of my knowledge, de On the basis of examination end/or i	28b. TIME OF INJURY M 1 me, farm, street, fectory, ath occurred at the time, revestigation, in my opinion	INJURY AT WORK? YES 2 NO office	281. LOCATION (Street City or Yown, Stets to the cause(a) end ma time, date end place, et	end Number or R	ural Roule Number, use(e) end manner se stated.
E COMPLETED BY	1	Inpetient 2 ER/Outpetient 3 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At hobuilding, atc. (Specify) IN: To the best of my knowledge, de On the basis of examination end/or in the examination end/or in t	28b. TIME OF INJURY M 1 me, farm, street, fectory, ath occurred at the time, revestigation, in my opini	INJURY AT WORK? YES 2 NO office date and place, and due on, death occurred at the	281. LOCATION (Street City or Yown, Stets to the cause(a) end ma time, date end place, et	end Number or R	ural Route Number, use(e) end manner es stated. SNED (Month, Dey, Year)
BE COMPLETED BY	1	□ Inpetient 2 □ ER/Outpetient 3 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At hobuilding, atc. (Specify) IN: To the best of my knowledge, de On the basis of examination end/or in the	28b. TIME OF INJURY M 1 me, farm, street, factory, with occurred at the time, mvestigation, in my opini ALUK 27 (Type, Print) SIREE 1	And the series of the series o	281. LOCATION (Street City or Yown, Stete to the cause(e) and may time, date and place, as MBER	end Number or R	use(e) and manner as stated. INED (Month, Day, Year) ARY 14 1998



State of Maryland / Department of Health and Mental Hygiene

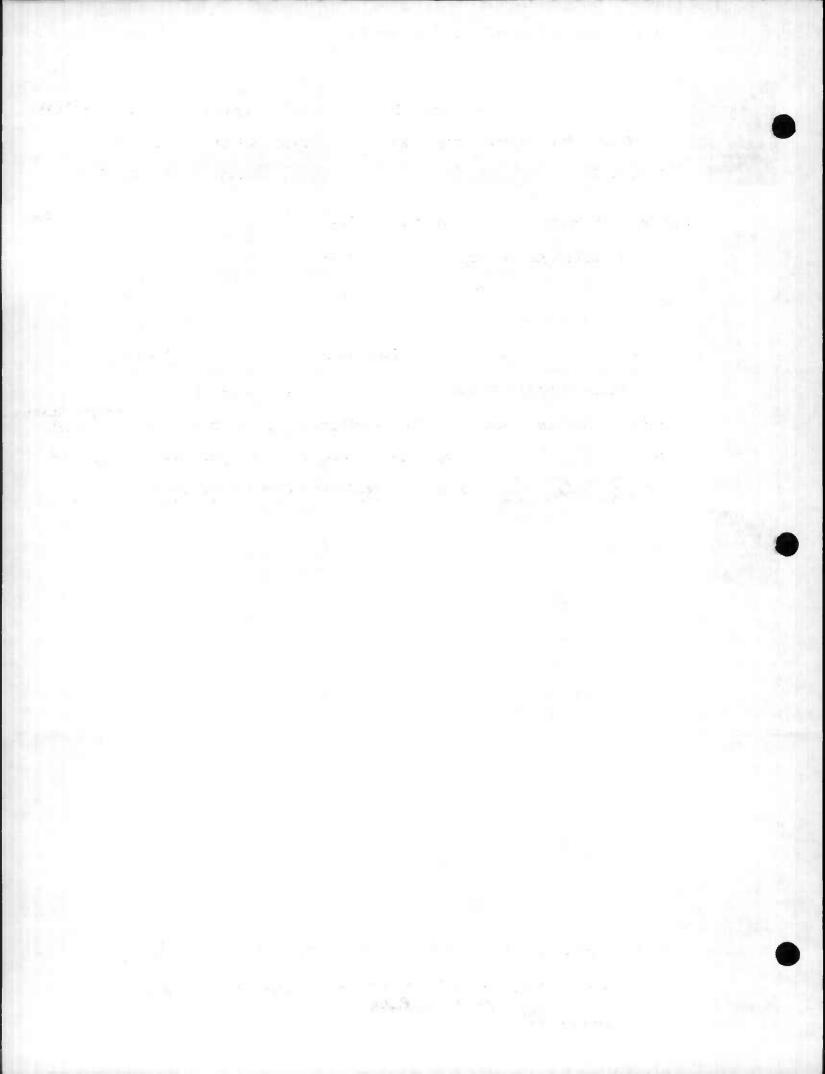
Dhusisis	_				Ce	rtificate of	Dealli		F	Reg. No.		
Physicia Medica/		Decedent's Name (First, Middle,	JO		IILLS,	JR.		J	2. Date of Dea Month January	I2,	<u>19</u> 98	3. Time of Death 9:30 AM
Examine	er	4a. Facility Neme (If not institution, s 105 Richards			. 3			own, or Loca isfiel	ation of Death		of Death merse	et
uneral rector		216-14-2196	5. Sex 15√2M 2□ F	7. Age (In yr. 7 (s. last birthday) Yrs.	If Under 1 Year Months Day		Min.	B. Date of Birth (Month, Day March	(), Year) 1921	9. Birthple Count Mai	ace (State or Fore y) yland
M to		Usuai Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	ocation					10	d. inside City Lim
28a-f sh	Director	Maryland Somers	set		Cri	sfield			1.	10a Citizan of U		OX Yas 2□
Sa or			on Arro	And	2	2181				10g. Citizen of V	vnat Count	ryr
	Funeral	105 Richardso 11. Maritel Status 1 Never Married 2 Married	12. Wes Dec	edent Ever in orces? WC	U,S. 13.	Was Decedent of If Yes, specify Cu	Hispenic Or ben, Mexical		fy Yes or No- can, etc.)		e - America k, White, e	
Exa	p	3 XWidowed 4 ☐ Divorced	Year or D	ve War	II	1□Yes 2⊠XNo	o Specify:			Specify	Whi	te
7 is marked other than "natural", traumatic event, ine Medical Exa	Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	grade completed)	1-4or 5+)		dent's Usual Occi kind of work don DO NOT use retir		st of working		16b. Kind of Bu		ustry
other ti		12			V	Vaterman	1			Seaf		
marked off	To Be	17. Father's Name (First, Middle, La John O. Mills	5				N	lolan	Tyler	<i>Maiden Sum</i> am		
Taur.		19e. Informant's Name/Reletionship	/	,		ng Address (Stree						
fitem 2 r other	-	John O. Mills, 20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3		Son)	Place of Dispo cemetery, crer	Richards sition (Name of matory or other pi	on Ave	- A	pt. 3	- Crisf 20c. Location -		
jury		4 ☐ Donation 5 ☐ Other (Spe	cify)			ry Crema			14/98	Salish	oury,	MD
important: i any injury c once.		21. Signature of Fundral Service Lice	consee Su	ut bu	22	Name and Add Bradsha	ress of Facili W & Sc	ons Fu	meral	Home		
	-	Robert H. 23a. Part1. Enter the disease, or conshock, or heart feilure. List on								eld, MD	1	Approximete
ding physicla se es the bur	VMed	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b		(or as a consequence of consequence	4005	3 /clex	na	164	Disei us ense	digr	grs e yn
igned by the etten be detached for u	Physician	Part II. Other significant conditions	contributing to d	eath but not re	esuiting in the u	nderlying cause g	given in Pert I	1.		obacco use cor		the causa of dealers
peng e	by L				1					2010	0 1100	iory 4 onki
has been si	Сощріетед			<u>. </u>					24a. Was a perfor		evei	e autopsy finding lable prior to pletion of cause eath?
pege pege	000								1 🗆 Y	es 25 No	1 🗆	Yes 2□ No
artific ector	a a	25. Was case referred to medical exeminer?	11					e of Death (Check only or	ne)		
this of di	0	1 No 2 No		-	☐ ER/Outpatien	I SLI DUA				ence 6 □Othe		
e funer	cation	27. Manner of Death 1 ☑ Naturai 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Sulcide 6 ☐ Could not	ion	of Injury th, Day Year)	28b. Time of Injury	M 1[Yes 2	No		ow injury occurr		
0 E		4 Homicide determine	200. Place	e of Injury - At ing, etc. (Spec	home, farm, str cify)	eet, factory, office	3	28	f. Location (S City or Tow	treet and Number, State)	er or Rural	Route Number,
illed in by the funer												
the Funeral Director pletely filled in by th	edical	29a. Certifier 1 X Certifying F (Check only one) 2 Medical Ex	Physician: To the aminer: On the band man	best of my kn asis of examin ner stated.	nowledge, death nation and/or inv	occurred at the restigation, in my	time, date an opinion, dea	nd place, and occurred	d due to the c at the time, d	ause(s) end ma late and place, s	nner as sta and due to	ted. he cause(s)
To the Funeral Director completely filled in by th		(Check only 2 Medical Ex	aminer: On the b	asis of examin	lowledge, death	estigation, In my	time, date an opinion, dea	d place, and occurred	at the time, d	ause(s) end ma late and place, s 19d. Date signed	and due to	he cause(s)
pletely fill	Medical	(Check only 2 Medical Expone)	o completed cause	asis of examinate stated. See of death (Ite	ention and/or investigation an	29c. Licer	opinion, dea	64	at the time, d	eate and place, and pl	and due to	he cause(s)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month **Physician** EVA MAE MATTHEWS 4:55 AM January 11, 1998 /Medical 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 5650 Crisfield Highway (residence) Marion Station Somerset | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplaca (St. (Month, Day, Year) | Oct. 2, 1911 | Maryland 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign **Funeral** Months 1□M 2X F Director 218-16-6602 86 Usual Rasidance of Decedant tha Manyland 10a Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examener must be nothed at 10d. Insida City Limits 1 ☐ Yas 2X No Directo Maryland Somerset Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5560 Crisfield Highway 21838 IISA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. hours aftar 1 Navar Marriad 2 Married 1 ☐ Yas 2 XNo If Yas, Giva Saltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: à 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16h, Kind of Business/Industry ifiled within 7: I Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 6 Homemaker At Home permit. Pages 1 and 2 should be filed to Department of Haaith and Mantal Hygie Important: if item 27 is marked other 1 eny injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Thomas Franklin Nelson 2 Marie Lankford 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State Zip Code) Marion Station, 19a. Informant's Neme/Ralationship (Type, Print) Louis N. Matthews (son) 8510 Crisfield Highway - PO Box 148 - MD 21838 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State St. Paul's Cemetery 1/14/98 Marion Station, MD 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Emeral Service Licensea

Robert H. Bradshaw 22. Nama and Addrass of Facility Bund hum Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intarval Batweer **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner DISEAJE COKONARY buriel-transit and Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Diseesa or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of) certificata be exec physician Box 68760 Physician/Medical the Dua to (or as a consaquance of). ettending for P.O. I Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown CHRONIC PULMONAKY DUEASE OBSTRUCTIVE Records. pa 24b. Wara autopsy findings availabla prior to complation of causa of daath? pege 2 should Completed 24a. Was an autopsy performed? Deen certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to madical Be 26. Place of Deeth (Check only ona) axaminer? 1:☐ Yas 2☐ No Hospital: Other: 4 Nursing Homa 5 Masidance 6 Othar (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this funerei To the Hospital or Attending Pr within 24 hours eftar death. To the Funeral Director: After th completaly filled in by the funere 27. Manner of Daath 28a. Data of Injury (Month, Day Yaar) Certification: 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida 1 Certifying Physicien: To the best of my knowledge, death occurred et tha tima, data end place, end due to the causa(s) and menner es steted.

2 Medicat Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the ceuse(s) and mannar stated. Medical 29a. Certifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) Vasantha Più P MD 98 D0051736 30. Name end addrass of person who complated causa of deeth (Itam 23a) (Typa, Print) Vasantha Pai, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Data filed (Month, Day, Year) 32. Registrar's Signatura Redell State JAN 1 5 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Patrick /Medical Victor 4b. City, Town, or Location of Deeth Moratin 98 7:10 PM 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 30823 Eden-Allen Road Wicomico Birthpieca (State or Foreign Country) if Under 1 Year 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 □ F Deys Director 576-24-5209 Usuel Residence of Decedent 68 04 22 Hilo, Hawaii 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, it a Modical Examiner must be notified at Director 1 Yes No MD Wicomico Eden 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 30823 Eden-Allen Road

11. Marital Status

1 □ Never Married 2 □ Married

2 □ Wildowed 4 ☑ Divorced

12. Wes Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ NowWII

1 □ Yes, Give
Yeer or Dates: permit. Peges 1 and 2 should be filled within 72 hours effer death w Department of Heelith and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items 23s to may injury or other traumatic event, the Wagnal Fearmants once. Funeral 21822

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No by Specify: White Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. Do NOT use retired)
Retired
Packing Foreman 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Naval Supply in 12 eman
Pearl Harbor
18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be tin Lydia Vieir 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Bruno Moratin 19e. Informent's Neme/Relationship (Type, Print) 30823 Eden-Allen Road, Eden, MD
20b. Pleca of Disposition (Name of cametery, cremetory or other plece) William A. Moratin/Son 20a. Method of Disposition D 21822 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) Salisbury Crematory 1/10/98 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility M01051 Holloway Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. 501 Snow Hill Road, Salisbury, MD 21804 Approximete intervel Between Onset and Deeth **Physician** /Medical tmmediete Cause (Finel diseese or condition resulting in death) **Examiner** Examiner mum mu physician and s the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) ettending p signed by the e Part tl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? should should 24e. Wes en eutopsy performed? pege 2 1 🗆 Yes 2 A No 1 ☐ Yes 2 ☐ No this certificate Division of Vital Hospital or Attending Physician: 24 hours effer death. 25. Wes case referred to medicat exeminer? director 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 2 Residence 8 □Other (Specify) funeral 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manper of Deeth edical Certification: 28b. Time of 28c. Injury et Work? Affer 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide n 24 hours of the Funeral Di pletely filled In within 24 hou To the Funer completely fill 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Yeer)

erson who completed cause of deeth (Item 23e) (Type, Print)

22. Registrer's Signature

Fall Stwelson Randell

145

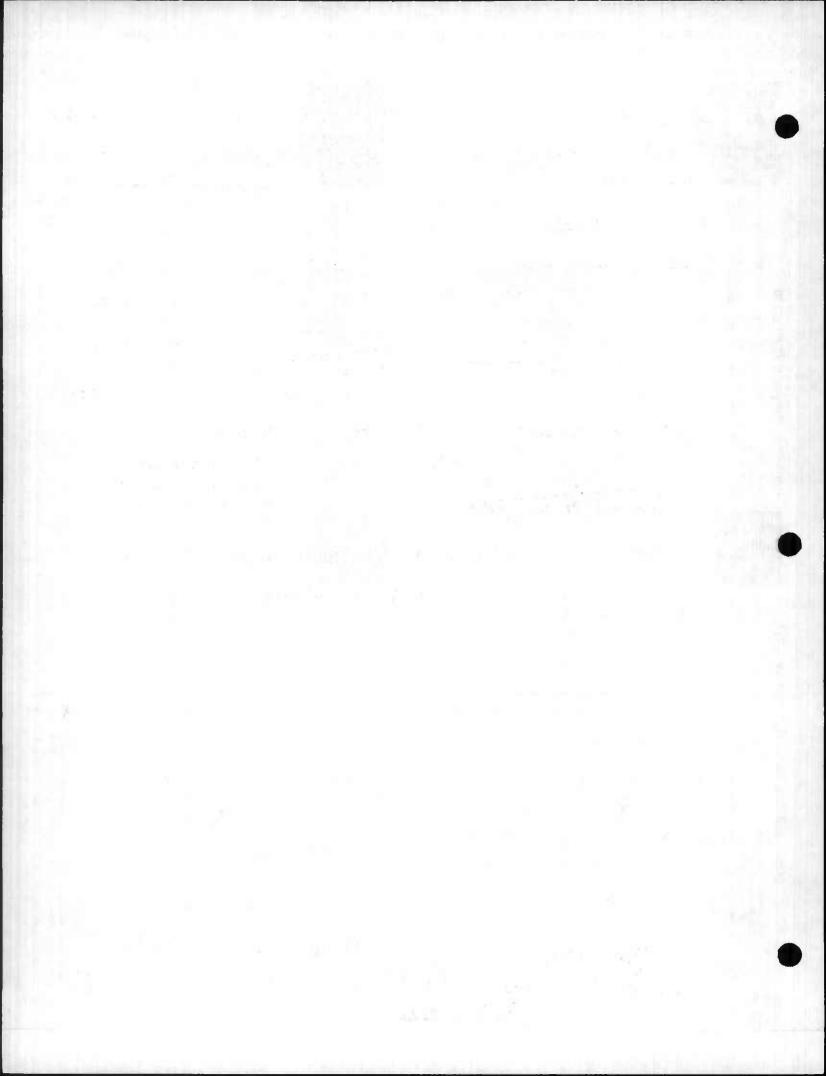
OZZAM

MARROLL ST SHUSRIMY MO

State Registrar

VA

9+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth DITHEL Zanuary 2,1998 tion of Deeth Stc. County of Deeth MILLER 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 2/19/15 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Days Hours 1 M 2 DyF 82 578-10-3499 Colorado Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1703 E. Gate Drive #106 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Sales Associate Department Store 17. Fether's Name (First, Middle, Last) Max Rabinoff Zelda 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 31029 Wilton Ave., Salisbury, MD 21804 a of Disposition (Name of Date 20c. Location - City or Town, Stete Phillip K. Miller/Son 20b. Plece of Disposition (Name of cometery, crematory or other place) Eternal Light Memorial Cardens 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 1/6/98 Boynton Beach, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Facility Holloway Funeral Home Holloway Funeral none 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Intervel Between Onset end Death our. 11. Enter the disease, or complications that caused block, or heart failure. List only one ceuse on each line. death. Do not enter Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown SIP AUR 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be find Department of Health and Mental Hy Important: If Nem 27 is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

than "natural", or items 23a or the Medical Examiner must be r

Director

Funeral

by

Completed

Be

2

the burial-transit as use

Physician/Medical Examine The law requires that the death cartificate be executed unaral director, or Attending within 24 hours aftar daath. To the Funeral Director: A tha filled in by

Box 68760,

P.O.

of Vital Records,

Division

Hospital

ile ile

by Certification: To Be Completed

Medicai

6

State

Registrar

1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier

(Check only one)

5 Pending investigetion 6 Could not be determined

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

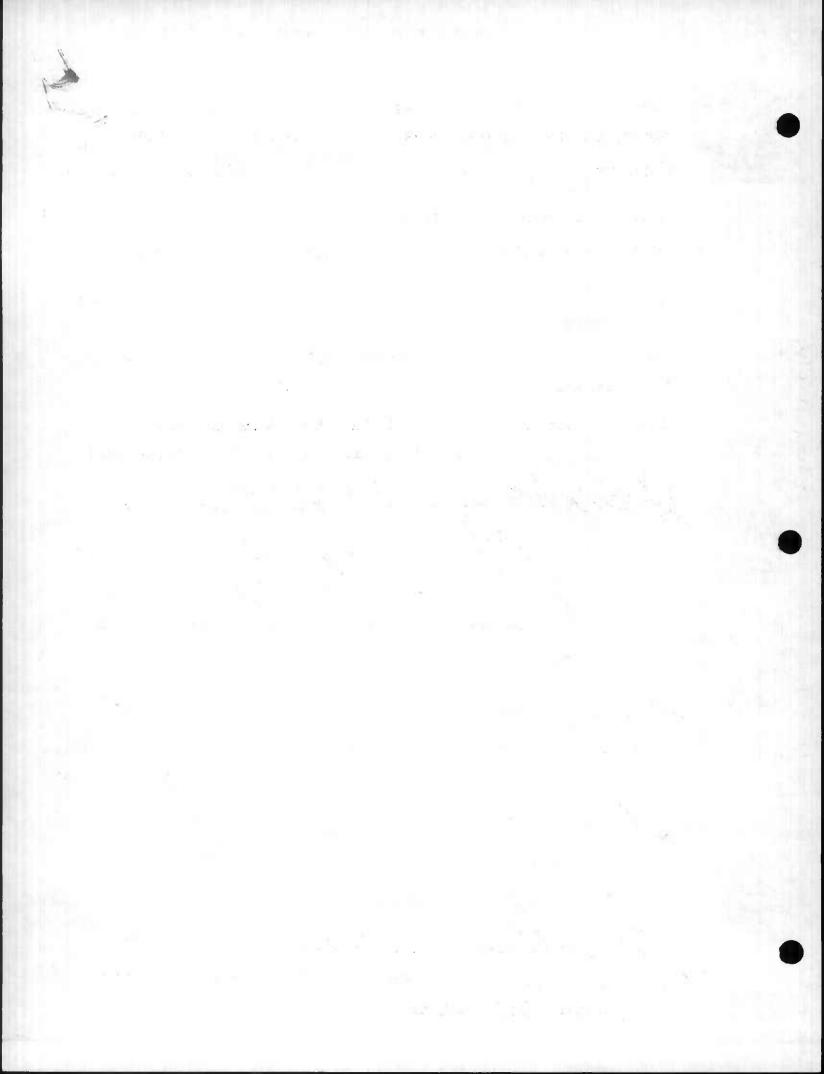
Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29b. Signature and title of certifier 29c. License number

end eddress of person who completed cause of death (Item 23e) (Type, Print)

(JUALTEROS 31. Dete filed (Month, Day, Year)

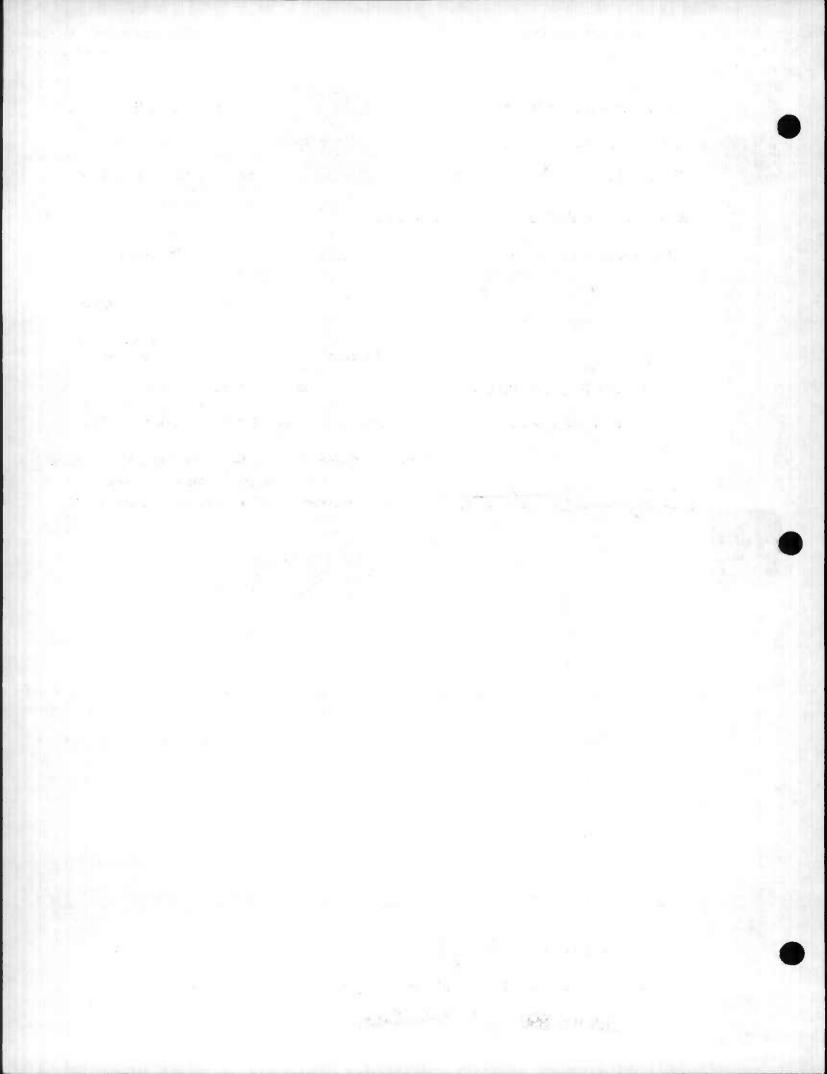
JAN 08 1998

262 Tilgaman Rd, Salisburg MD 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 8

					Certi	illicate (of Death		Reg. No.		
		1. Decedent's Name (First, Middle, L	ast)	- X	Tarib	T DES		2. Dete of D	eeth		Time of Death
Physicia /Medic		Charles Willia	m Nusbaum	, Sr.				Januar	y 1, 199	98 5:	55 P.M
Examin		4a. Facility Name (If not institution, g					4b. City, Town	, or Location of Dee			
		Frederick Memor	ial Hospit	al			Fred	erick	Fred	erick	
Funeral Director		5. Social Security Number 6. 212–32–3350		ge (In yrs. lest	t birthday) Yrs.	If Under 1 Y Months De		Hrs. 8. Dete of B Min. (Month, D Nov. 4	ay, Year)	9. Birthplace (Country) Marylan	Stete or Foreig d
*		Usuel Residence of Decedent 10a. State 10b. County		10c City T	own or Loca	ation				10d In	alda City I Imit
sho	5	Maryland Freder	rick		ederic						slde City Limit ☐ Yes 2 N
28a-1	Director	10e. Street end Number	LICK	FIC	edelic		4.		40.000		
23a or		8607 Chestnut G					701			d State	
"natural", or items 23a or 28a-f show solical Examinet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:	?	If Y	as Decedent Yes, specify (Cuban, Mexican, P	? (Specify Yes or N ruerto Rican, etc.)		ca - American Ind ck, White, etc. Whit	
"natural", adical Exa	Completed	15. Decadent's l (Specify only highest g		1	6e. Deceder	ent's Usual Or	ccupation	working	16b. Kind of B	usiness/Industry	
than "	nple.	Elementary/Secondery (0-12)	College (1-4or	5+)	life. DC	O NOT use re	one during most of etired)	Working	State	Dept. o	f
	So	12			Shop	Forem	an		Transp	ortatio	n
al Hygie Jother	Be	17. Fether's Neme (First, Middle, Las	st)				18. Mother's	Name (First, Middle	, Maiden Sumen	ne)	
is marked or reumatic eve	၉	Charles Gray	son Nusba	um			Nell	ie Herme	se Six		
S THE		19a. Informent's Neme/Relationship	(Type, Print)		19b. Meiling	Address (St	treet and Number o	or Rural Route Num	per, City or Town,	Stete, Zip Code)
Haalth lem 27 i		Frances Nusbaum	/ wife		8607 (Chestn	ut Grove	Rd./ Fre	derick,M	ld. 2170	1
2 2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		came	etery, crema	ition (Neme of atory or other vet Cer	of rplace) metery	Date 1-5-98		ck, Mar	
mportant:		21. Signature of Funeral Service Lice	ensee					Stauffer			,
eny ir		10. 6	75_1		1.00	01.0					
		23a. Part1 Enter the disease, or cor shock or heart feilure. List only	-eleccion that anyon	d the death I				Pike/ Fr			O2 oximate val Between
ysician /ledical		Immediete Cause (Final disease or condition	no.O.	-1		1	1			1	
aminer	ner	resulting in death)		Due to (or es	s e conse	encelon	rylge	tuit.	4	4-	-5d
	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Cert	Due to (or es	s e conseque	ence of):	dias	tuit	,	9-	-5d
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ing physician and e as the buriel-trensit	Medical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated eyents	c	Due to (or as	s e conseque	ence of):	dia,	terite	I tobacco use co	ntribute to the o	-5 of
ing physician and e as the buriel-trensit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	c	Due to (or as	s e conseque	ence of):	dia,			ntribute to the o	
been signed by the ettanding physician and should be datached for use as the buriel-trensit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	c	Due to (or as	s e conseque	ence of):	dias	1 = 24e. We		3 Probably 24b. Were au eveilable	4 Unkno
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s cartificata has been signed by the ettanding physician and director, pega 2 should be datached for use as the buriel-trensit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions	b. Contributing to death b	Due to (or as	s e conseque	ence of): ence of): derlying cause	26. Place of	24e. We per 1 C	Yes 2 No s en eutopsy ormed? Yes 2 No one)	3 Probably 24b. Were au eveilable completi of deeth	4 Unkno
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Trous are used. The standard present After this cartificate has been signed by the ettending physician and interest birector. After this cartificate he should be datached for use as the buriel-trensit by filled in by the funerel director, pega 2 should be datached for use as the buriel-trensit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 Homlcide 4 Homlcide 1 Certifying P 2 Medical Examiner) 2 Medical Examiner 2	Hospital: 28a. Date of Inju. (Month, Date of Inju. 28e. Placa of Inju. building, et	Due to (or es	Outpetient b. Time of Injury c, farm, stree	ence of): ence of): ence of): dertying cause 28c. M et, fectory, off	26. Place of Other: 4 □ Nursl Injury et Work? 1 □ Yes 2 □ No fica	24e. We per 1 Death (Check only ng Home 5 Res 28d. Describe 28f. Location City or To lece, end due to the	Yes 2 No s en eutopsy ormed? Yes 2 No one) ildenca 6 Oth how Injury occur (Street and Numbown, Stete)	3 Probably 24b. Were au eveilable completion deeth 1 Yes per (Specify) red per or Rural Roundanner as steted, and due to the completion of the completi	4 ☐ Unknown topsy findings a prior to so on of cause? 2 ☐ No
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98-0127-013 Item 23a Part I, 27, 28a-f, per MEO, 01/16/98, Carroll County, wj1 Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene LIAM ANDREW OHARA Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey **Physician** LIAM ANDREW O'HARA 9 JAN. 1998 0800 AM /Medical 4e Fecility Neme (If not institution, give street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WESTMINSTER CARROLL 29 WESTMORELAND STREET If Undar 1 Yaar If Under 24 Hrs Months Deys Hours Min. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foraign Country) 6. Sax 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Months 1⊠M 2□ F 15 Yrs 216-15-0392 Director 7/31/1982 AUSTRALIA Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at X Yas 2 No MD. CARROLL WESTMINSTER Directo 10e. Street end Number 10f. Zip Code 10g. Cifizen of Whet Country? 21157 29 WESTMORELAND STREET USA. Funeral Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Reca - American Indien, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Yes 2 No 1€ Never Married 2 Merried 1 ☐ Yes 2 ◯ No Specify: Maryland 21215-0020 Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) STUDENT EDUCATION 10 other 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event once. 17. Fethar's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) Be O'HARA MICHAEL BONNIE LYNN BLACKISTON 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) -FATHER MICHAEL O'HARA 29 WESTMORELAND ST., WESTMINSTER, MD. altimore, 20b. Placa of Disposition (Name of cematery, cremetory or other piece) Data 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/12/98 METRO CREMATORY BALTIMORE, MD. □ Donetion 5 □ Other (Specify) 22. Nama and Addrass of Fecility FLETCHER FUNERAL HOME of Feneral Servi 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heert failure. List only one ceuse on eech line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Finel Narcotic intoxication diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest physician and the buriel-tren Due to (or as a consequenca of): certificete be Physician/Medical Dua to (or es a consequence of) es esn Ö the 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to Completed 24a. Was an eutopsy completion of cause of deeth? page 2 has Yes 2 No Yes 2 No certificate Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SXResidence 6 Other (Specify) 1X Yes 2 No To this funeral Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of fnjury 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending efter death. 1 Tes 2 No **Unknown**^M investigation 1-9-98 2 Accident Unknown 6 Could not be determined 3 Suicida 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 29 Westmoreland St 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide Found at home 24 hours e Westminster, MD 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end dua to the ceuse(s) end menner es steted. Medical completely Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner stated. To the To the To the I 29b. Signati 29c, License number 29d. Data signed (Month, Day, Year)

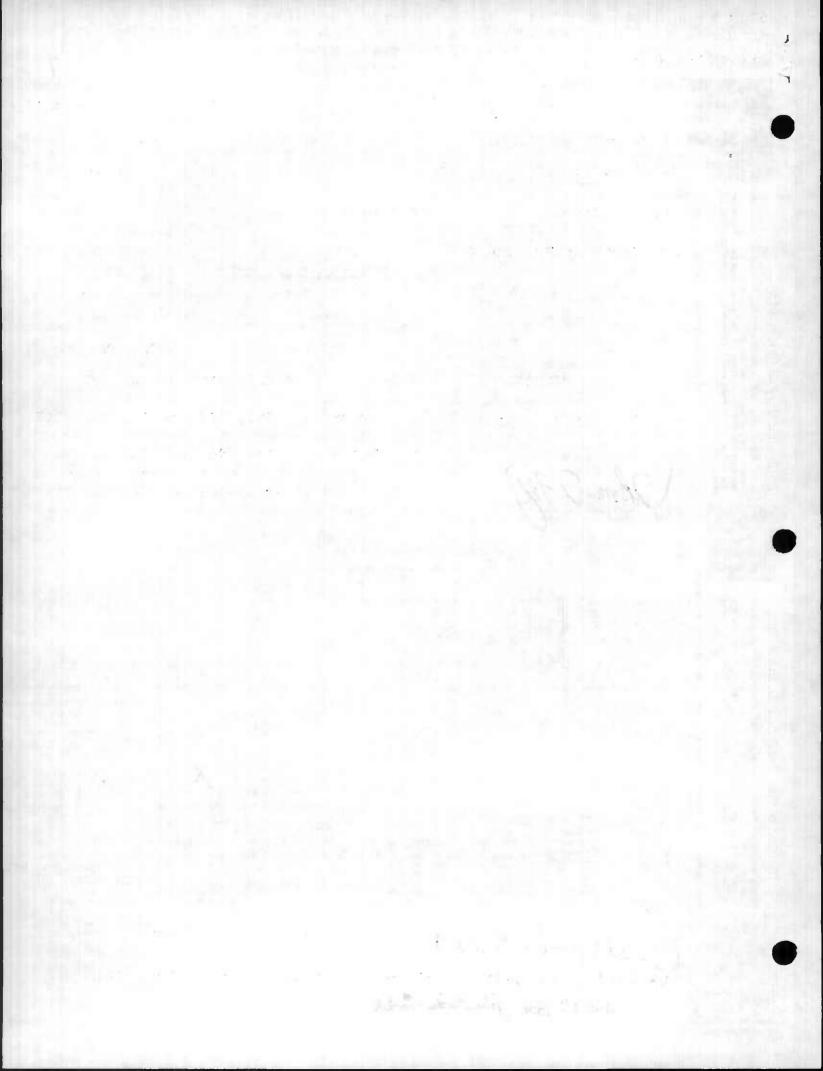
Registrar

end address of person who completed cause of deeth (Item 23e) (Type, Print)

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

JAN. 9, 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 119198 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Year BERNICE January 1998 10:30 am **OWENS** /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Salisbury Wicomico Nursing Home Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 78 Yrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 6. Sex Birthpiece (State or Foreign Country) **Funeral** 1□M 2☑F Deys 262-16-0903 **Director** Florida Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 7 is marked other than "natural; or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 10d. Inside City Limits 1⊠ Yes 2 No Wicomico Director Maryland Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pine Bluff Village 21801 USA 12. Wes Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft Depertment of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or I any Injury or other treumstic event, the manual space. 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic Housewife 11 Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) William B. Wilson Bamma Mae Sauls 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara I. Womack/Daughter 306 S. Clairmont Dr., Salisbury, MD 21801 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Shady Lane Cemetery 1/7/98 Scranton, PA 5 ☐ Other (Specify) 4 Donetion Funerel Service Ligense 22. Name end Address of Fecility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Put1. Enter the disease, or complications that which died the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

April 100 Complete C Approximete Intervel Between Onset end Deeth nd Stage Rend Failure

Due to (or es e consequence of): **Physician** /Medical Immediete Ceuse (Finei diseese or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants resulting in deeth) Lest pue ettending physiclen e Box 68760 phno Physician/Medical Due to (or es e consequence of) the signed by the eld be deteched for P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructure Primon Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of death? Be Completed 24e. Wes en eutopsy 1 deane page 2 this certificate hes 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director, I 25. Wes case referred to medical examinar? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P edical Certification: 27. Mennar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physicfan: To the best of my knowledga, death occurred et the time, dete end plece, end dua to the causa(s) end menner es steted.

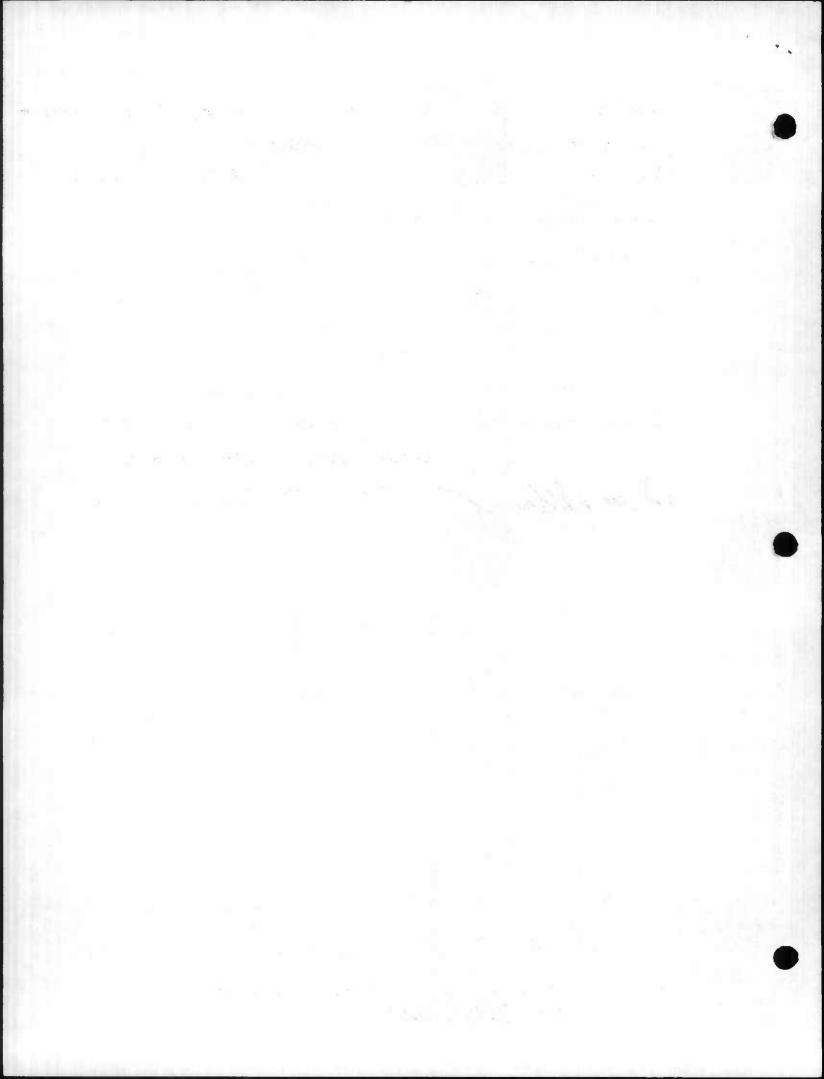
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and dua to the causa(s) end mennar statad. 29a, Cartifier (Check only one) 29b. Signeture end title of certif 29c. License number 29d. Dete signed (Month, Dey, Year) 302026 30. Neme and eddrass of parson who completed cause of death (Item 23a) (Type, Print) Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811 32 Registrer's Signeture 31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

State

Registrar

JAN 06 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month
January 12 1-Month **Physician** 825 PUSEY JEANNE /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year Months Deys If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 01/18/1923 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 F Months 74 Director 217-16-9470 Maryland Usual Residence of Decedent 10a Slate 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Directo Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 West Main Street 21826 U.S. Funerai items ; 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, While, etc. The Medical Examiner filed within 72 hours after 1 Never Married 2 Married ò 1 Yes 2 10 Specify p Specify: 3 Widowed 4 □ Divorced White 'natural'. Completed 16a. Decedent's Usual Occupelion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Wicomico County 12 i. Peges 1 and 2 should be filed w itment of Health end Mantal Hygian tant: If Item 27 Is marked other th itury or other traumatic event, In-Clerk Dept. of Social Services Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Samuel Reed Chaffey Mabel McGee 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lloyd M. Pusey, Jr. Son 415 West Main Street, Fruitland, Md. 21826 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from Stete 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Andrews Episcopal Cem 1/16/98 Princess Anne, Md. 22. Name end Address of Fecility ture of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave, Princess Anne, Md. 21853
Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest,
or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physiclan** /Medical Immediate Ceuse (Finel eavs disease or condition resulting in death) Examiner Examiner requires that the daath certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of) buriel-tran Physician/Medicai tha Due to (or es e consequence of): 80 esn datached Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? ate has been signed by page 2 should be datac 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy The law 1 ☐ Yes 2 ☐NO 1 Yes 2 No Attending Physician: director. Be 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this illed in by the funeral 27. Manner of Deeth Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred Affer 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records, of Vital Division 24 hours after death. Hospital or within 2 To the

To the

21215-0020

Baltimore,

State Registrar

completely

Medical

29a. Certifier

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

JAN 16

30. Name end add ss of person who completed cause of deeth (Item 23a) (Type, Print) herton

32. Registrer's Signature 1998

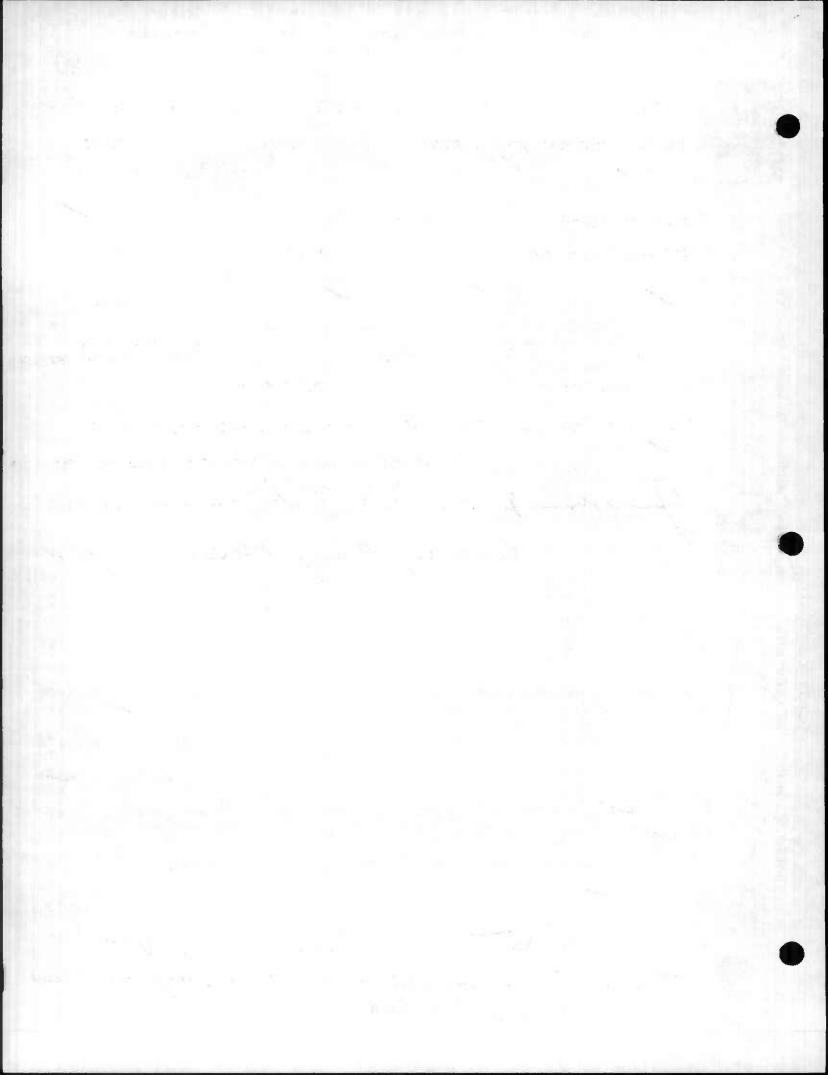
PRIME SANSBURY UND

1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date end place, end due to the cause(s) end manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

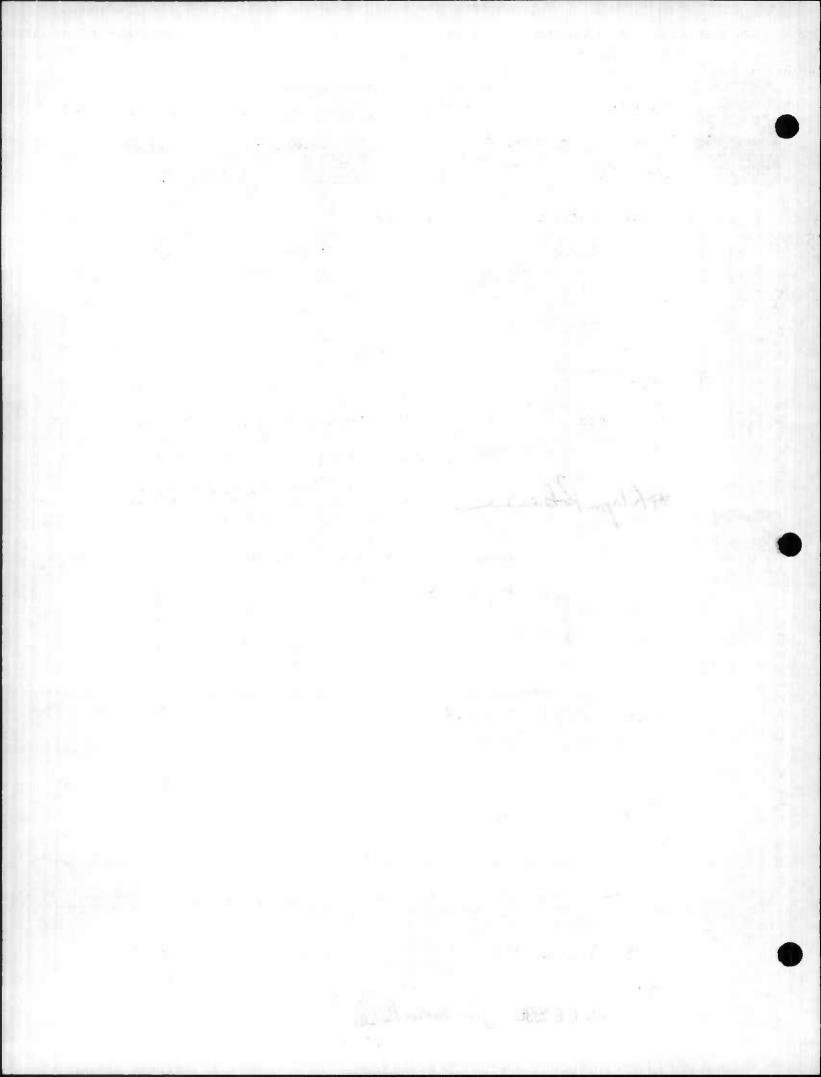


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Day Kornelia Rhodes January 2, 1998 5:00 P.M. /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Day, Ye Sep 18, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F Months 83 Yrs. 527-42-1030 Director Holland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, its Medical Examinat must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Director Frederick 1 ☐ Yes 21 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7017 Arbor Drive 21703 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ÊNo If Yes, Give Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 11. Meritel Stetus 1 Navar Merried 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Reinder Lucas Van Oosting Anke Haak 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John M. Burdette/Attorney 22 West Second Street, Frederick, Maryland 21701 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 □ Cremation 3 □ Removel from Stete Mt Olivet Cemetery Jan 7, 1998 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Nama and Address of Fecility
Keeney & Basford P.A. Funeral Home 21. Signeture of Funaral Service 106 E Church Street, Frederick, Maryland 21701 Part 1. Entar the disease, or complications thet causad tha death. Do not antar tha mode of dying, such as cardiac or respiretory arrast, shock, or heer failure. List only one ceuse on eech line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Heart disaasa or condition rasulting in death) Examiner Examiner ypertension or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan for use es the buria Physician/Medical Due to (or as a consequence of) signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Osler - Weber - Randu þ 24b. Wera autopsy findings evallable prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? certificete 1 Yes 1 ☐ Yas 2 No 25. Wes cese referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 0 1 Yes 2 No this 27. Menner of Deeth 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? After 5 Pending investigation Neturel ours after death.

Neral Director: Aft
filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours at To the Funeral C completely filled Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. 29a. Certifier 29b. Signatura and title of cartifiar 29c. License number 29d. Date signed (Month, Dey, Year) Tolene MD 0516100 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Ave 31. Dete filed (Month, Day, Yeer) Suite 204 Frederick. 32. Ragistrar's Signatura State JAN 0 6 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Remsburg Clinton 4, 1998 5:15 P.M. January /Medical 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick H Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) 5. Sociel Security Number 6. Sex Birthplace (Steta or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2□ F Months 220-09-8067 Yrs. Jan Director 18 1911 Manyland Usual Rasidance of Decedant the Meryland 10a. Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be nottled at Frederick t Yas 2 No Director Brunswick 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1100 Peach Orchard Lane Funeral death 21716 USA 12. Wes Decedent Ever In U.S. Armed Forcas?

1 Yes, Give Yaar or Datas: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 72 hours efter 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🛣 No Specify: þ Specify White "naturai", 3€Nidowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "s any injury or other traumatic event, it a Med Elementary/Secondary (0-12) College (1-4or 5+) B & O Railroad Brakeman 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be Jacob M. Remsburg Ava Pearl Annold Remsburg 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Rt. Box 191, Hanpens Fenny, WV 25425

Jama of Data 20c. Location - City or Town, Stata Joan E. Shipe 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovel from State Lutheran Cemetery 1/7/98 Middletown, MD 4 □ Donation 5 □ Othar (Specify) 21. Signature of Finaral Sarvica Licensea William 22. Nama and Addrass of Facility
John T. Williams Funeral Home
100 Petersville Rd Brunswick MD 21716 Banbana A. Williams, Owner 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical tmmediate Cause (Final Chronic Obstructive Pulmonnsy diseese or condition rasulting in daath) **Examiner** Dua to (or as a consequanca of): Examine ettending physicien and for use es the bunel-trensit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Lest Dua to (or as a consequance of): be exect Records, P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 15 Yes 2 No 3 Probably 4 Unknown Heart Failure by 24b. Were autopsy findings evailebla prior to complation of causa of daath? Completed 24a. Was an autopsy performed? certificate has 1□ Yas 2 No 1 ☐ Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case refarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No P 28c. Injury et Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 1 Natural 2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datarminad 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicida Tertifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and mennar steted. edicai 29a. Certifian (Check only one) 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Date signed (Month, Dey, Year)

State Registrar

JAN 0 7 1998

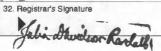
31. Data filad (Month, Day, Year)

Toney

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30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

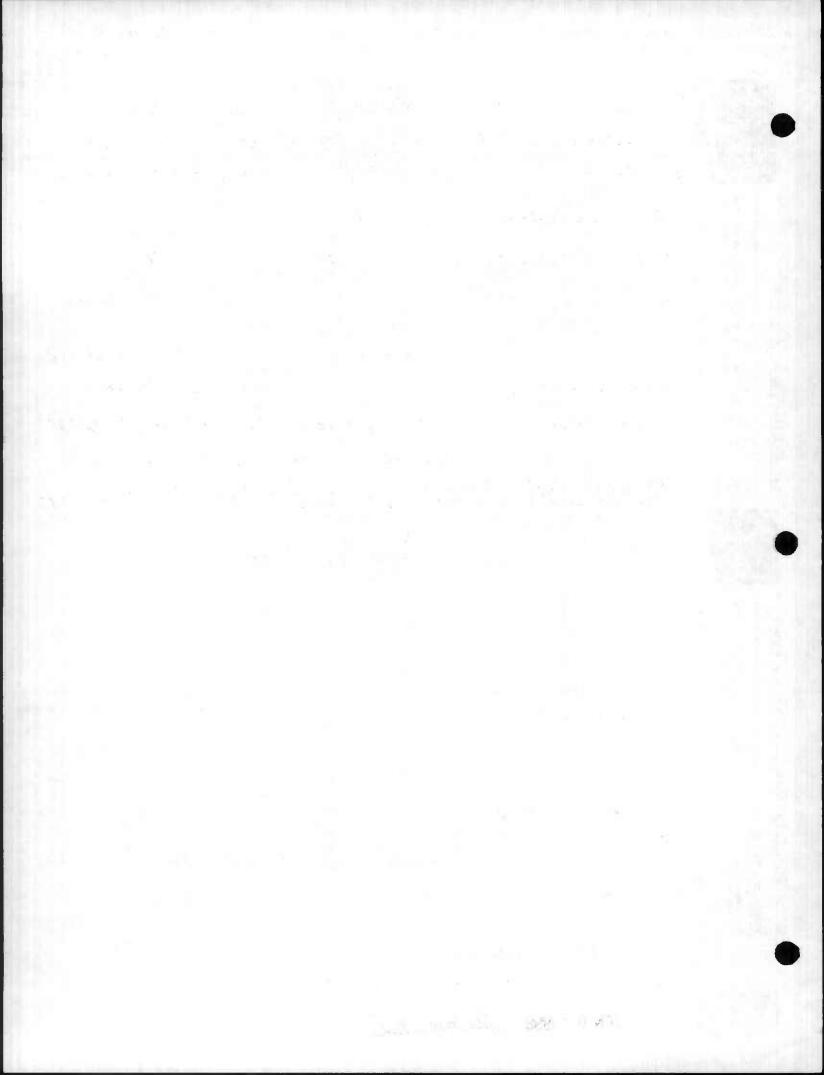


Suite

204

VhO 0516100

Frederick, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SPAHR WILLIAM 1:05 PM D JAN 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Ba If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) University of Maryland Medical Center Baltimore City 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthdey) 1⊠M 2□ F Yrs. 213-08-7419 25 May 11, 1972 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Frederick Thurmont 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11218 Putnam Road 21788 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Specify: white 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Harris, Smariga College (1-4or 5+) 11 Surveyor and Associates 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Keith Spahr Sandra L. Swomley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Sandra L. Swomley / mother 11218 Putnam Road, Thurmont, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ResthavenMemorialGardens 1/7/98 Frederick, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland21702 23a. Pert1. Enter the disease, or complications that caused the denshock, or heart failure. Ust only one cause on each line. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel diseese or condition resulting in death) CIERIZIBRAL INFARCTION 1 DAY Due to (or es e consequence of): lrft subdurkl HEMATONA 3 DAYS Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): STRUCK VIZHICLE 3 DAYS BY MOTOR Alas Due to (or es e consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMPLE Contribute to the cause of death?

23b. Did tobacco 4 2 Probably 4 Unknown DIABRIES INSIPIDUS 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

Physician /Medical Examiner

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Attending Physician:

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To the Hospital within 24 hours e To the Funeral Completely filled

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Box 68760

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Records,

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Physician

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Examiner

10a State

Funeral

Director

Items 23s or 28s-f show

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I Hygiene.

Peges 1 and 2 should be finent of Health end Mentel I hut: If item 27 Is marked of

other

Depertment of Health er Important: If item 27 Is any injury or other traughter.

traumatic event, the Medical Examiner

filed within 72 hours after

21215-0020

Maryland

Baltimore,

Director

Funeral

by

Completed

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Examiner Physician/Medical by Completed Be 2

Certification: in by the

Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

25. Was cese referred to medical

1 Yes 2 XNo 1 ☐ Yes 2 ☐XNo 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28c. Injury et Work? Pedertrian Struck by auto 1 ☐ Yes 2 No

1 Naturel 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide

1 Yes 2 No

27. Manner of Deeth

28a. Dete of Injury (Month, Dey Year) 12-31-97 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of Injury 2352

Street

281. Location (Street and Number or Rurel Route Number, City or Town, State) Route 15 and Mountain Doll Road, Fredrick County MD

29a. Certifier

TE Certifying Phyelclen: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier Pretton 29c. License number 77-22260 29d. Date signed (Month, Dey, Yeer) 198

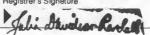
JOHN S.

22 S. GREENE STREET, BALTIMORIE, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

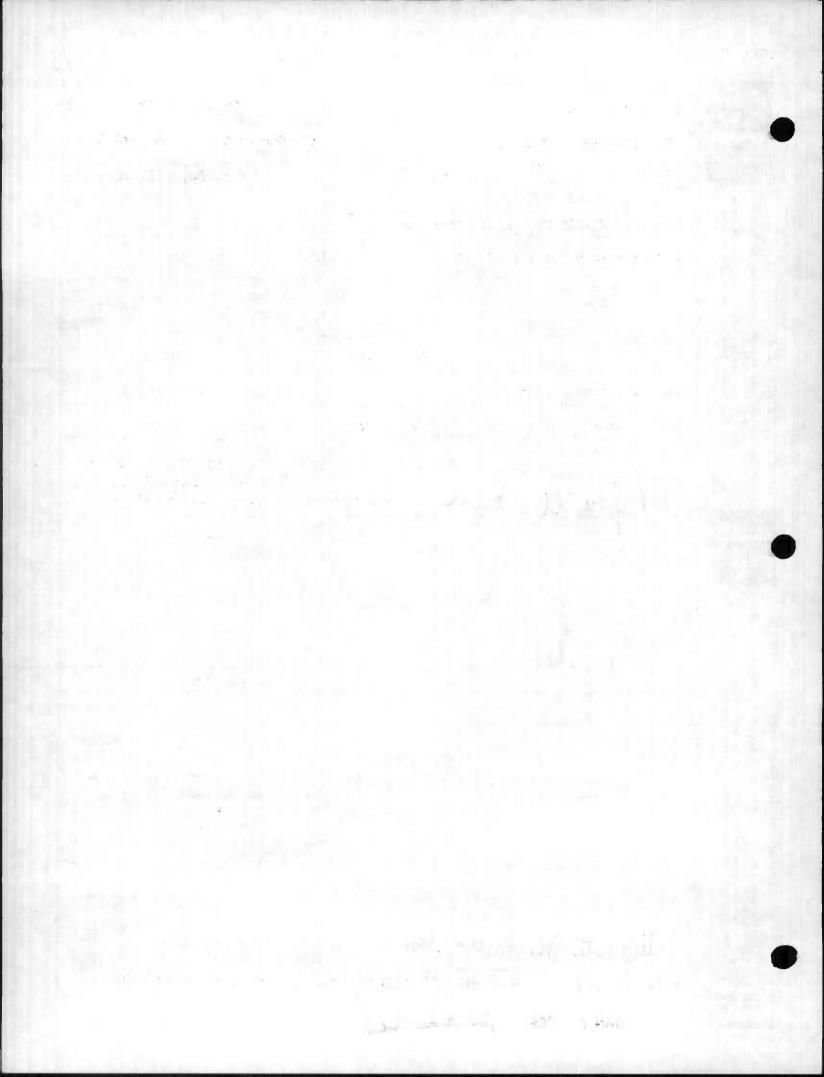
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30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

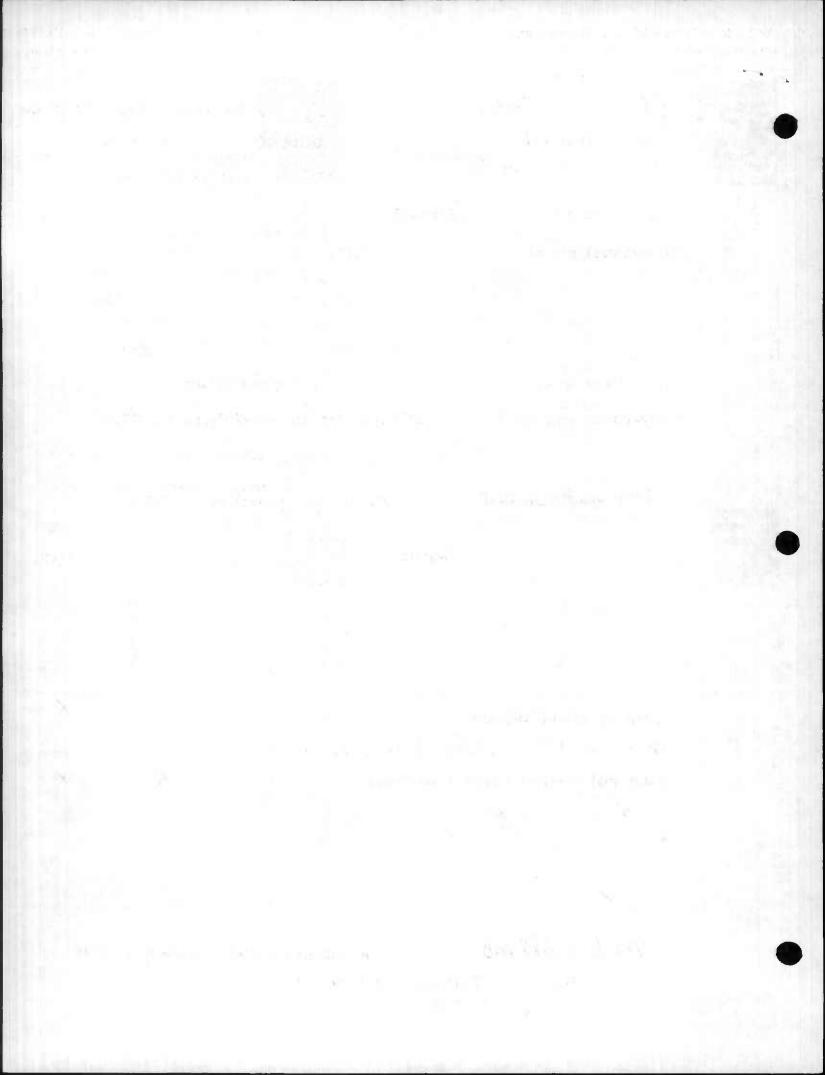




ETER SAUTEI Items:23a par	R t I,27 per MEO G -7 56 2,	State of Mary /18/98 dh		rtment of F			giene Reg. No.	01	733
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Funeral	5. Social Security Number 6. S	Sex 7. Aga (In	yrs. last birthday)	Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da	th i <i>y, Year)</i>	9. Birthplace Country)	a (Stata or Foreign
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pu *	Usual Residence of Decedant 10a. Stata 10b. County	100	c. City, Town or Loc	ation				10d	Insida City Limits
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be filed within 72 hours after deeth with the Meryland ital Hygiene. d other than "natural", or items 23a or 28s-f show event, the Medical Evaninet must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Wes Dacedent Evar Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Datas:		Yes, specify Cub ☐ Yes 2 No	Hispenic Origin? (Spean, Maxican, Puarto Specify:	Rican, etc.)	Specify	ck, Whita, atc.	
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Mental be srked o atic eve o	Hubert Eugene Sau	ıter			Joyce Ar	n Hinse	enkamp		
of and	19a. Informant's Name/Ralationship (Typa, Print)	19b. Mailing	Addrass (Street	and Number or Rur			Stete, Zip Co	oda)
and 2 n 27 Is or trau	Hubert Sauter, fa	ather	4091	Lomar Dr	., Mt. Ai	rv. MD	21771		
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artmen ortant: injury	21. Signatura of Funaral Sarvice Lice	-	Hagerstow 22.	Nama and Addre	ass of Facility Sta	/0/90	Hagerst	OWIL, I	aryland
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Carrier Co.	23a. Parti. Erie tha disease, or com- shock, or heart failura. List only	Micatilitie that could dibe		-	sumtown Pi				21702 pproximata
death certificate be axecuted e ettending physician and ad for use as the buriel-transit	Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last	bDua	to (or as a consequence to (or a conseq	uence of):					
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hat tha di ad by the datached	Part II. Other significant conditions of	contributing to death out no	trasuming in the un	daliying caosa gi	ven m Petti.		-		bly 4 Unknow
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certificeta rector, pag	25. Was casa raferrad to medical examinar?				26. Placa of Daa	th (Chack only	one)		
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To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 7	27. Manner of Death 1 XXIII 5 Panding 2 Accident invastigatio 3 Sulcide 6 Could not b		ar) 28b. Tima of Injury	28c. Inju Wo M 1	rry at ork?] Yas 2 ☐ No		how injury occur		
al or Att is aftar d in Direct ed in by	3 ☐ Sulcide 6 ☐ Could not be determined		At home, farm, stra pecify)	et, factory, office			(Street and Numi wn, State)	ber or Rural R	louta Number,
To the Hospital within 24 hours a To the Funeral Completaly filled		nyaician: To the best of my niner: On the basis of exa and manner stated.							
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	30, Nama end address of parson who MANY DOWN	1. Konen	111 Penr		, Baltimon	re, Mar	yland 21	201	
State Registrar	31. Data filed (Month, Day, Yaar)	32. Ragistrar's S	Signatura P.						



		County - sk			Certific	ate of	Death		Reg. No.	U	734
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or Items	Funeral	11. Marital Status	12. Was Dacedant I Armed Forcas?		13. Was Da It Yas, s	acedant of specify Cut	Hispanic Origin? (S oan, Maxicen, Puart	specify Yes or No to Rican, atc.)	o- 14. Rad Bla	ce - Amaricen Indian, ack, Whita, atc.	
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of Herr fram othe		20e. Mathod of Disposition		20b. Place of cemeter	Disposition (/	Nema of or other pla	ace)	Data	20c. Location -	City or Town	n, State
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Departi Import any inj once.		21. Signature of Funeral Sarvica Licensea Page Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784									
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rtificate has bee stor, pege 2 sho		axaminar?	Hospitel: 1 Inpatia	nt 2 ER/Ou	tpatient 3	DOA Ot	har		idance 6 □Oth	ar (Specify)	
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ne Hospital or Attending Physicien: The lat in Ed-Wurder of the death. The Cardinate has pletely filled in by the funeral director, page 2 pletely filled in by the funeral director, page 2	ledical Certification: To Be	27. Mannar of Deeth 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifiar (Check only one) 27. Mannar of Deeth 5 Pending Invastigati 6 Could not datamine	28a. Place of Injubuilding, atc	ry - At homa, fai (Specify) I my knowladga, axamination and	daath occurr dor invastigati	red at the ti ion, in my 29c. Lican	opinion, daath occu	City or To	wn, Stata) causa(s) and me date and place, 29d. Data signe	end due to the	ed. a ceusa(s) y, Year)



State of Maryland / Department of Health and Mental Hygiene 98

					Cert	ificate	of	Death		F	leg. No.			
Physic	ian	1. Decedent's Neme (First, Middle, Las	t)							2. Dete of Dee Month		Yeer		ne of Deeth
/Med		Otis Tyler								01	14	98	10	:00a.m
Exami	ner	4e. Fecility Name (If not institution, give								cation of Death		ty of Deeth		
		Alice Byrd 5. Sociel Security Number 6. Se		rsing e (In yrs. lest bir		If Under 1	Vear		sfie		_	merse		- 110
Funeral Director			M 2□ F	00	crrcus,		Days	Hours	B. Chan	8. Date of Birth (Month, Dey Feb. 6,	1909	Mary.	ntry)	ete or Foreign
yland		10a. Stete 10b. County		10c. City, Tow	n or Loca	ation						1	10d. Insid	de City Limits
e Mai	ctor	Maryland Somer	set	Ev	vell								1 🗆	Yes 2 No
th with th	ai Director	10e. Street end Number 20966 Caleb Jo	ones Road			10f. Zip C		324		1	0g. Citizen o US		ntry?	
filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or items 23a or 28a-f show ont, the Marijcal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 MWidowed 4 Divorced	12. Wes Decedent E Amed Forces? 1 Ayes 2 N If Yes, Give Yeer or Detes:	World		as Deceder res, specify Yes 2		dispanic Orig an, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		aca - Americ ack, White, ify: Wi		
d within 72 hours af giene. or than "neturel", or or weller! Even	eted	15. Decadent's Ed (Specify only highest grad	ucation le completed)	16e.	Deceder	nt's Usuel	Occup	oetion during most	of worki	na	16b. Kind of	Business/In	dustry	
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should be nd Mental marked o	2	Andrew Schul	-							tansbur	-			
nd 2 lith a 27 is r tree		19a. Informent's Name/Reletionship (T. Robert Carl Tyler								- Ewell	-) Code)	
		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,			y, creme	tory or other	er pla	ce) netery	1	Dete /17/98	20c. Location Ewell		own, Stet	е
permit. Page Department of Important: If eny injury or once.		21. Signeture of Foreral Service License Robert H. Br	Budake	w	E	Brads	nav	ess of Fecility & So lain S	ns F	uneral Crisfi	Home eld, M	D 218	17	
Physician /Medical Examiner	ner	Immediate Ceuse (Finei disease or condition resulting in death)		s biraf Due to (or es e c			u	rmol	úa					end Deeth
e executed an and unal-transi	Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or es e o	conseque	enca of):								
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that the ed by th detache	y Physician	Pert II. Other significant conditions co	ntributing to death bu	t not resulting in	the unde	erlying cau	se giv	ven in Part I.		23b. Dld to	11			use of death?
aw requires as been sign 2 should be	Completed by									24a. Was a perion		ev:	eilable pr	osy findings rior to of cause
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	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injur building, etc.	ry - At home, fer (Specify)	m, street	t, fectory, o	ffice		2	28f. Location (St City or Town		nber or Rura	i Route I	Vumber,
To the Hospital or within 24 hours ath To the Funeral Dir completely filled in	edical	29e. Certifier (Check only one) Certifying Physical Examt	sicien: To the best of ner: On the basis of e end manner stet	my knowledge, exemination end ed.	deeth or Vor Inves	ccurred et l stigetion, in	he tir my o	ne,-dete end pinion, deeti	plece, e	and due to the co	euse(s) end mate and plece	nanner es si , end due to	teted. the ceu	se(s)
within To th	M	29b. Signeture end little of cartifier				29c. L	icans	e number		2	9d. Dete sign	ed (Month,	Dey, Yee	er)
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		30. Name end eddress of person who co	unathan, M	i.D 2	01 F	Hall H	lig	hway .	- Cr	isfield	, MD 2	1817		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Rose	lall								

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State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Daniel James Tunnell 0115 Jan. 6, /Medical 1998 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) **Funeral** XXM 2DF 222-01-6621 87 Yrs. Director 7/2/1910 Delaware Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23e or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Delaware Sussex Frankford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19945 Rt. 2 Box 185 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 2 3 10 1f Yes, Give Year or Dates: Was Decedent of HIspanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 Married 2 should be filed within 72 hours eften and Mental Hygiene.

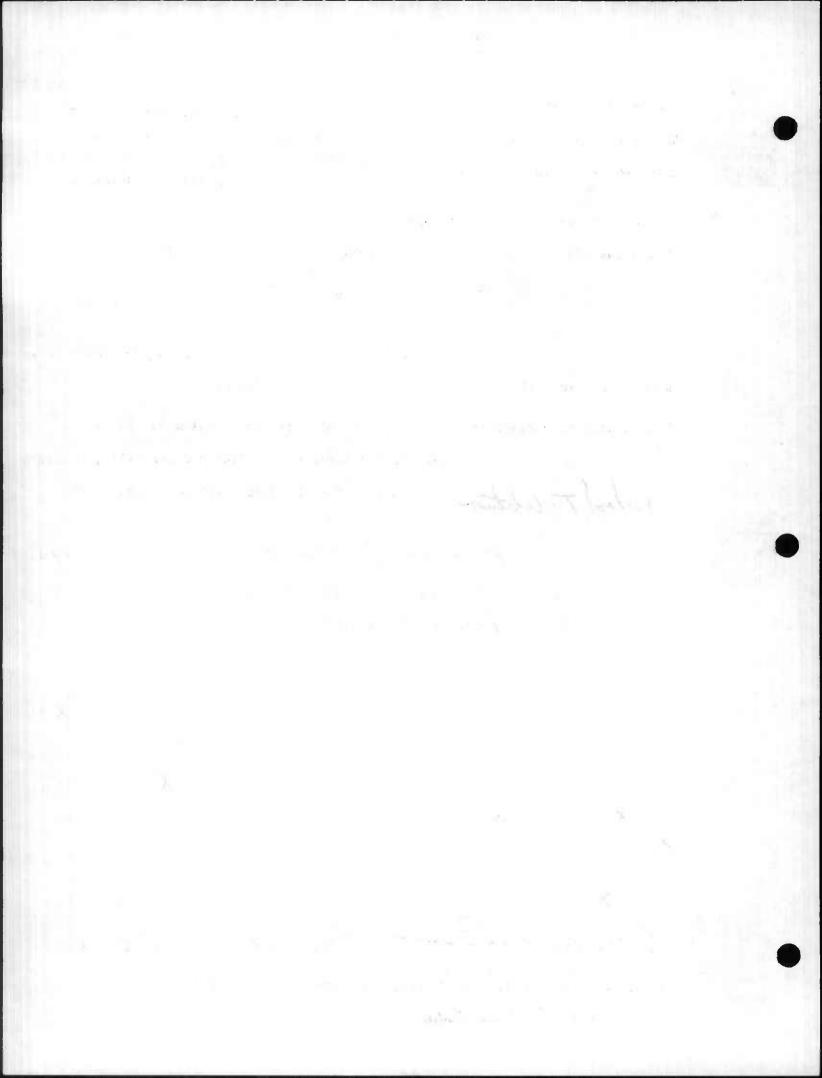
Is marked other than "netural", or it Baltimore, Maryland 21215-0020 1 Yes ZNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) laborer food processing ind. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Isaac Daniel Tunnell Allie Showell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health end Important: If Item 27 is m any Injury or other traum Rt. 2 Box 185, Frankford, Delaware 19945 Bettie Walters - daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/10/98 Clarksville, Delaware Union Wesley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Watson Funeral Home, Millsboro, Del. 19966 23a. Perf1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Onset and Death **Physician** RESPIRATORY FAILURE

Due to (or as a consequence of):

SEVERE DEHUDRATION

Due to (or es a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physician end s the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Last Box 68760 Due to (or as a consequence of) use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Records, by 24b. Were autopsy findings eveilable prior to Completed 24a. Was an autopsy performed? peeu completion of ceuse of death? has page 2 1 ☐ Yes 2 ☐ No certificete Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, t 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b, Signature and illerof certifier 29c License number 29d. Date signed (Month, Dey, Yeer) шини D46257 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Edwin Castaneda, M.D., 314 Franklin St., Berlin, Md. Julia Dan Registrar's Signature 31. Date filed (Month, Dey, Year) State JAM 08 1998 Registrar

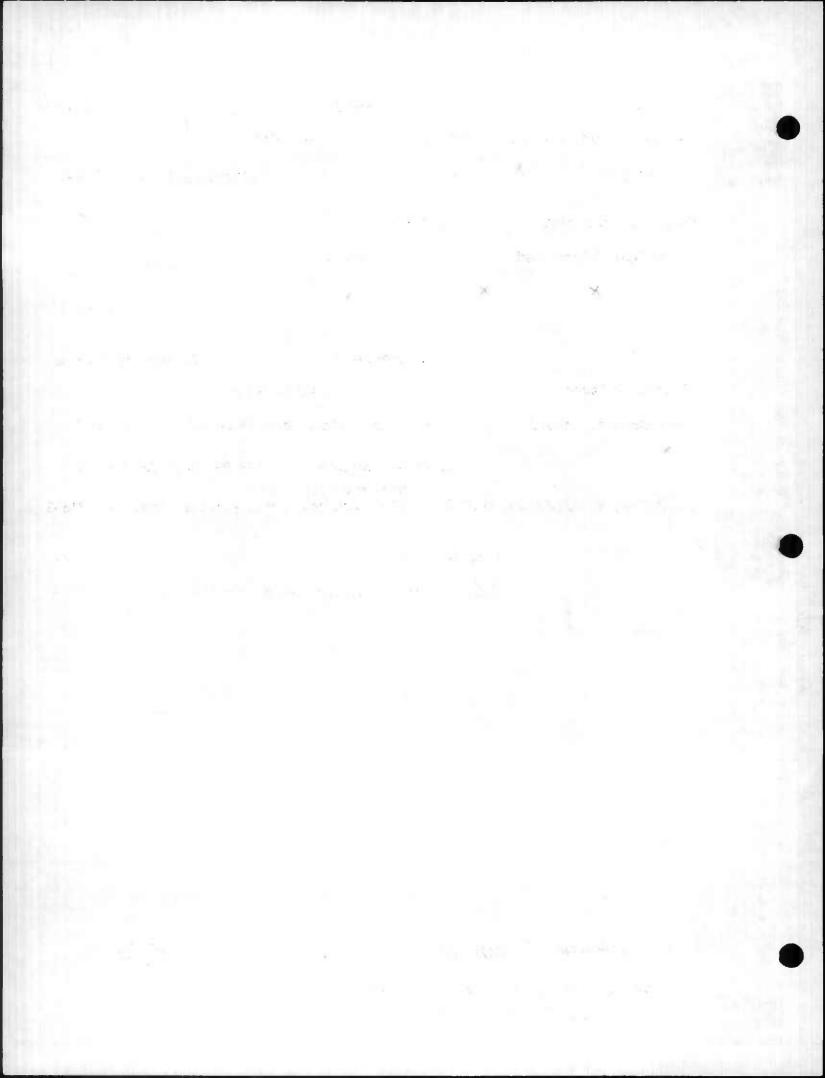


			State of Maryland		partment ertificate			nd Me		iene	Ul	131
Di i -		1. Decedent's Neme (First, Middle, Las	()					2.	Dete of Deet Month	th Dey	Yeer	3. Time of Deeth
Physic /Medi Examir	cal	Allard Wendell 4e. Facility Neme (If not institution, give	Wiles estreet and number)		4		4b. City, Tov	-	anuary	3, 1	998	11:03 PM
, Exami		Frederick Memori	al Hospital				Frede	rick		Frede	rick	
Funeral Director		5. Social Security Number 6. Social Security Number 219–20–2286 Usuel Residence of Decedent	9x X M 2□ F 7. Age (In yrs. In 6	Van	Months I	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Dey, July 4	Year) 1930		olece (State or Foreign otry) 1 Land
Menylend I-f show	tor	10a. State 10b. County Maryland Frederic		Town or							1	0d. Inside City Limits 1 → Yes 2 → No
th with the 23a or 28a	Funeral Director	10e. Street end Number 502 Schley Avenue			10f. Zip C	ode 702			1	0g. Citizen of U.S		nfry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show my highly or other traumatic event, the Modern Examples my be notified and	by	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,s Armed Forces? 1 ☑ Yes 2 ☐ No If Tes, Give Year or Detes: Kore.		3. Wes Deceder if Yes, specify	r tr	lispenic Orig en, Mexicen, Specify:	in? (Specif , Puerto Ric	y Yes or No- en, etc.)		ce - Americ ck, White,	etc.
72 ho	eted	15. Decedent's Ed (Specify only highest great	ucation de completed)	16e. Dec	cadent's Usuel ive kind of work . DO NOT use	Occup	etion during most	of working		16b. Kind of B	usiness/In	dustry
A I X I S-00 X O d within 72 hours aft glena. r than "natural", or r the world Eram	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life C	overnme	retired ent	Emp1c	yee		N.I.H.		
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should b nd Mente marked	To	James Lester Wil	es				Viola	a A. S	Swomley	7		
Maryiano d 2 should be file th and Mental Hy 7 Is marked oth trsumatic event		19a. Informent's Name/Reletionship (7			oiling Address (
end ealth m 27		DaEtta M. Wiles/W: 20a. Method of Disposition			Schley sposition (Neme		enue,			Maryla 20c. Location		
Physician /Medical Examiner	ler	21. Signature of Fundral Service Lieuwa 23a. Part I. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Finel disease or condition resulting in deeth)	e. Due to (or	Do not e	sequence of):	RTH of dylr	MARKE MARKE ng, such es d	7 & SCET ST.	FREI	DERICK,		
ocarificate be axecuted anding physician and use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	c. Conosc	es e cons	sequenca of):							900
The law requires that the death certificate hes been signed by the ettending phage 2 should be detached for use es it	/ Physician/M	Pert II. Other significant conditions or	ontributing to death but not resu	lting in the	underlying ceu	use giv	ven in Pert i.			obacco use co		o the cause of deeth?
e law requires hes been sign ge 2 should be	Completed by								24a. Wes e perfor	n autopsy med?	ev ev	ere eutopsy findings relieble prior to empletion of cause deeth?
The fa									1 🗆 Y	es 🔊 No	1 [☐ Yes 2☐ No
Physician: The This cartificate and director, peg	Be	25. Wes cese referred to medical examiner?	Hospital:			Ott	nor:		Check only or			
al di	Certification: To	1 Yes 2 No 27. Menner of Deeth Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	26e. Date of Injury (Month, Dey Year)	ER/Outpet 28b. Time Injury	of 280 y M	c. Injui Wo	70110	260 No	d. Describe h	ence 6 Oth	rred	fy) el Route Number,
To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral		4 Homicide determined 29a. Certifier 1 Certifying Phy	26e. Place of Injury - At ho building, etc. (Specify yelclan: To the best of my know	vledge, de	eath occurred et	the ti	me, dete end	d piece, end	City or Tow	n, Stete) euse(s) end m	enner es s	steted.
the Ho thin 24 I the Fu	Medicai	(Check only 2 Medical Exam	Iner: On the basis of examinet end manner stated.	on end/or	Investigetion, In	n my c	opinion, deet	th occurred	et the time, d	late end plece,	end due t	o the cause(s)
5 til 5 00		29b. Signature end title of certifier			290.	FIGALIS	e number					
		30. Neme end eddress of person who	completed cause of death (Item	23e) (Typ	e Print)		46 :	26		1001	3	1998
St		31. Dete filed (Month, Dey, Year)	32. Registrar's Signet		wn	t ag	50	1	rele	-109	Ma	71701

State Registrar

State of Maryland / Department of Health and Mental Hygiene

						Certifi	icate	of Deat	h		Reg. No.	0 0	1130
Physician		1. Decedent's Neme (First, Middle, L.	ast)							2. Dete of I	Deeth	Yeer	3. Time of Deeth
/Medical	L	ANNE				WE	EBST			Janu	any 6	1998	0950
Examiner		4e. Fecility Name (If not institution, g PENINSULA REGION	AL MEDIC		TER			SAI	LISBU	ocation of De RY	eth 4c. Coun WICO	ty of Death MICO	
uneral irector		5. Sociel Security Number 6. 222–16–1557 Usuel Residence of Decedent	Sex 7 1 □ M 2 F	. Age (In yrs.			Under 1	Year If Und Deys Hour	er 24 Hrs. s Min.	8. Date of I (Month, 02/23	Birth Dey, Yeer) 1/1923	9. Birthple County Mary.	
Mo to	-	10a. Stete 10b. County		10c. C	ty, Town	or Locatio	n					10	d. Inside City Limi
1 5 P	2	Maryland Somers	et	Dea	1 Ts	land							1 Yes 2□N
or 28a-f s be notified	20	10e. Street end Number		, 500			Of. Zip C	ode			10g. Citizen o	f Whet Countr	ry?
23a		9990 Deal Island	Road				21	821			U.S		
"naturel", or items 23a or 28a-f show of cal Examiner name be notified at lated by Elipseral Director	c c	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es?	J,S.			t of Hispenic (Cuben, Mexic		ecify Yes or I Rican, etc.)	No- 14. Re Bi	ace - America eck, White, e	
f, the Medical	200	15. Decedent's I			16a.	Decedent's	s Usuel (Occupetion	act of word	ina	16b. Kind of	Business/Indu	
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matic e	2	Carroll Walters							ce Tv				
traumatic		19e. Informant's Name/Relationship			1						nber, City or Tow		
other	-	Gene Webster/Hust 20e. Method of Disposition	Janu	20b		Disposition			Road,	Date	Island,	PICI. ZJ	
ui Assura	1	21. Signature of Funeral Service Lio 22a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that cau	100295 used the dea th line.	th. Do no	Hinn 1167 of enter the	me end and and and and and and and and and a	Address of Fed	Home Ave.	e , Prir or respiretory		ne, Md	
an/Medical Examiner	income.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>a</i>	Due to (of as a co	naequenc	oe of):	dineses	ulu	Su	eau		YKS
etached for us Physician	0	Part II. Other significant conditions	contributing to dea	th but not res	ulting in	the underly	ying cau	se given in Pa	rt I.	23b. Di	d tobacco use c	ontribute to t	the cause of deat
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rector, pa		25. Was case referred to medical examiner?	Hospital:		-		-	1 - 3 - 3 - 3	ice of Deat	h (Check onl)	r one)		
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fune floor	5	1 SeNatural 5 □ Pending	The second secon	Day Year)	28b. Ti	jury		Nork? 1 Yes 2	TNo	200. Descrio	e how injury occi	urrec	
nely filled in by the funeral		2 Accident Investigate 3 Suicide 6 Could not determine	pe 28e. Place o	finjury - Ath Lefo. (Speci	ome, fan fy)			Carlot		28f. Location City or 7	(Street and Nun own, State)	nber or Rural	Route Number,
edical		29a. Certifier 1 G-Certifying P (Check only 2 Medical Exa	hysician: To the be miner: On the bas and manne	is of examina	wiedge, ition and	death occi for investig	urred at gation, in	the time, date my opinion, d	and place, eath occur	and due to the	e cause(s) and r e, date and place	nanner as sta s, and due to t	ted. the cause(s)
completely filled Medical Ce		29b. Signature and title of certifier	-				29c. L	icense numbe	e		29d, Date sign	ed (Month, D	ay, Year)
		> Strala	m. h	M an)		-	10688			1/6	188	
	1	30. Name and address of person who	completed cause	of death (Item	n 23a) (1	PRI	no				100		
State		DONALD M 31. Date filed (Month, Day, Year)	2 1998 Per	MD pistury Signy	Mirele	PRI Conservation	MC C	3 68					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day JANUARY 10, 1998 ROBERT 0300 THOMAS WELLS, JR. 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Yaar Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 11X M 2□ F Months Hours MARYLAND Usual Residence of Decadani 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1A Yes 2 No Somerset Princess Anne Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11966 Jeffrey Lane 21853 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14 Bace - American Indian Black, White, etc. ₩ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 Widowad 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Infant none none 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Thomas Wells Bonnie Lynn Bozman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 11966 Jeffrey Lane, Princess Anne, Md. 21853 ace of Disposition (Nama of Date 20c. Location - City or Town, State Robert T. Wells/Father 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State St. Peters U.M. Cemetery 1/13/98 Oriole, Md. 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Facility Hinman Funeral Home 21. Signature of Funerel Service Licenses Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Princess Anne, Md. 21853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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Box 68760.

P.O.

Records,

Division of Vital

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or Attanding Figure 6 efter death.

To the Hospital

Department of Health and Important: If Nem 27 is m any injury or other traum

Physician

/Medical

Examiner

n/a

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at

Maryland 21215-0020

altimore,

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Pages 1 and 2

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Funeral

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burial-transi end physician the 88 guipo etten Por the signed by I 9 page 2 certificate this After After death.

Examiner Physician/Medical þ Completed Be 10 Certification: within 24 hours e To the Funeral E Medical

25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatiant 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending investigation injury 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

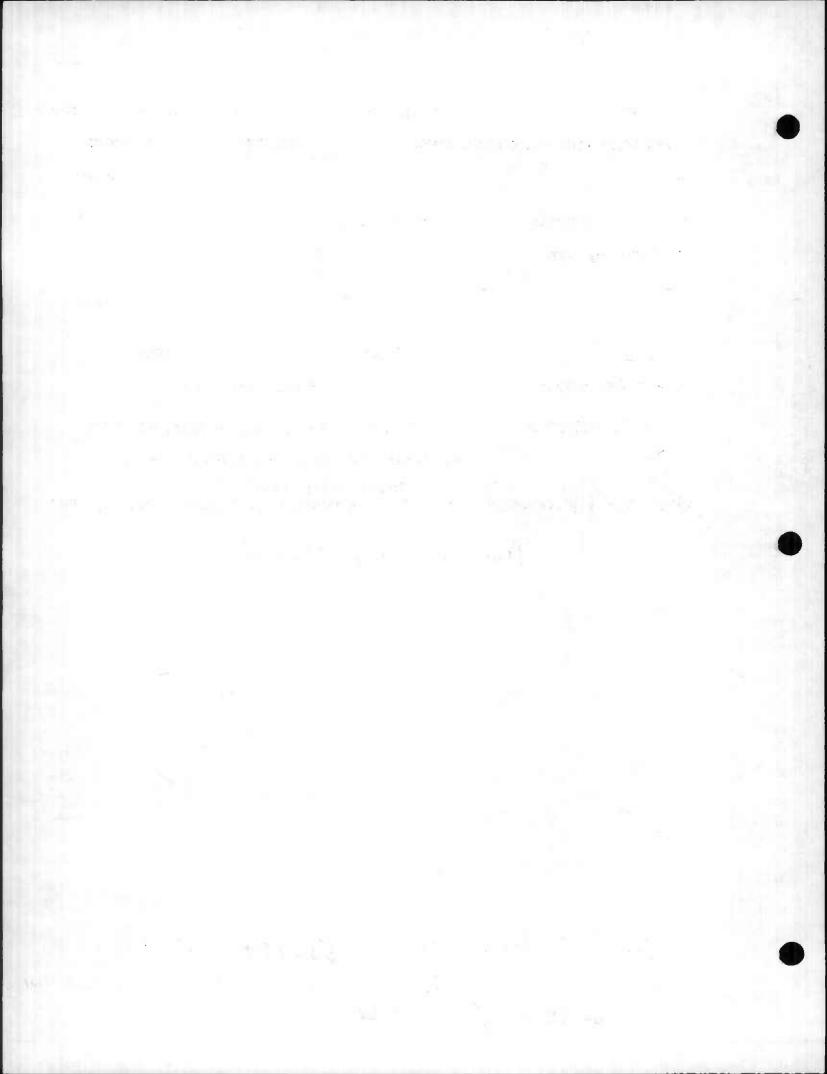
Beninsula Regional Squisaunt, no. 21501

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifian

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 2 1998 > Juli Davidson Rardall

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Daath Day Month Voor January 8, 1998 Harry Ward 7:10 PM Lee 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury, Salisbury Center: Genesis ElderCare Wicomico MD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sex Birthplaca (Stata or Foraign _Country) 1 M 2□ F Months Days 1905Stockton, MD Yrs 92 221-01-4272 Usual Rasidence of Dacedant 03 06 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No MD Wicomico Parsonsburg 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 21849 33580 Rohm Road USA Was Dacedent Ever in U.S. Armad Forcas? 13. Was Dacadant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indien, Black, Whita, atc. 1 Yes 2 No 1 Yes, Giva Yaar or Datas: 1 Never Marriad 2 Married 1□ Yas 2⊋ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White WWII 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Poultry 8 Grower 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Selby
19a. Informant's Name/Ralationship (Typa, Print) Ward Lula Pruitt 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 33580 Rohm Road, Parsonsburg, MD 218 and Disposition (Nama of Data 20c. Location · City or Town, Stata Helen Bradford/Niece 21849 20b. Placa of Disposition (Nama of cametery, cramatory or other place) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 1/10/98 Salisbury, MD Salisbury Crematory 21. Signature of Funared Service Moons 22. Nama and Addrass of Facility Holloway Funeral Home, P.A. 501 Snow Hill Road, Salisbury, MD 0 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death Immediate Cause (Final disaasa or condition rasulting in daath) 4417. Dua to (or as a consaquanca of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiatad avants rasulting in death) Last Dua to (or as a consaquence of): Dua to (or as a consaguance of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Wara autopsy findings eveileble prior to complation of ceusa of daath? 24a. Was an autopsy muff wang 2 □ No 1 Tas 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axamipar? Othar: 1 Nas 2 No 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

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Funeral

Director

Item 27 is marked other than "netural", or items 23e or 28a-f show other treumstic event, the Medical Examiner must be notified at

e filed within 72 hours after al Hygiene. other than "netural", or ite

12 should be fi end Mental F Is marked ot

permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 Is m any Injury or other treum once.

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

of Vital Records.

Division

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death

Examiner Physician/Medical by Completed

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Certification:

27. Manner of Death

Natural

2 Accident

3 Suicida

29a. Certifiar (Check only one)

4 | Homicida

29b. Signatura and title of certifian

William Robins

5 Panding invastigation

6 Could not ba

attending physician and for use as the burial-transit certificate be exec ed by the a signed by to has al or Attending Physics setter death.

al Director: After this could in by the funeral direction. To the Hospital within 24 hours e To the Funeral Completely filled

State Registrar

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

29c. Licensa number

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

1 Cartifying Phyaictan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

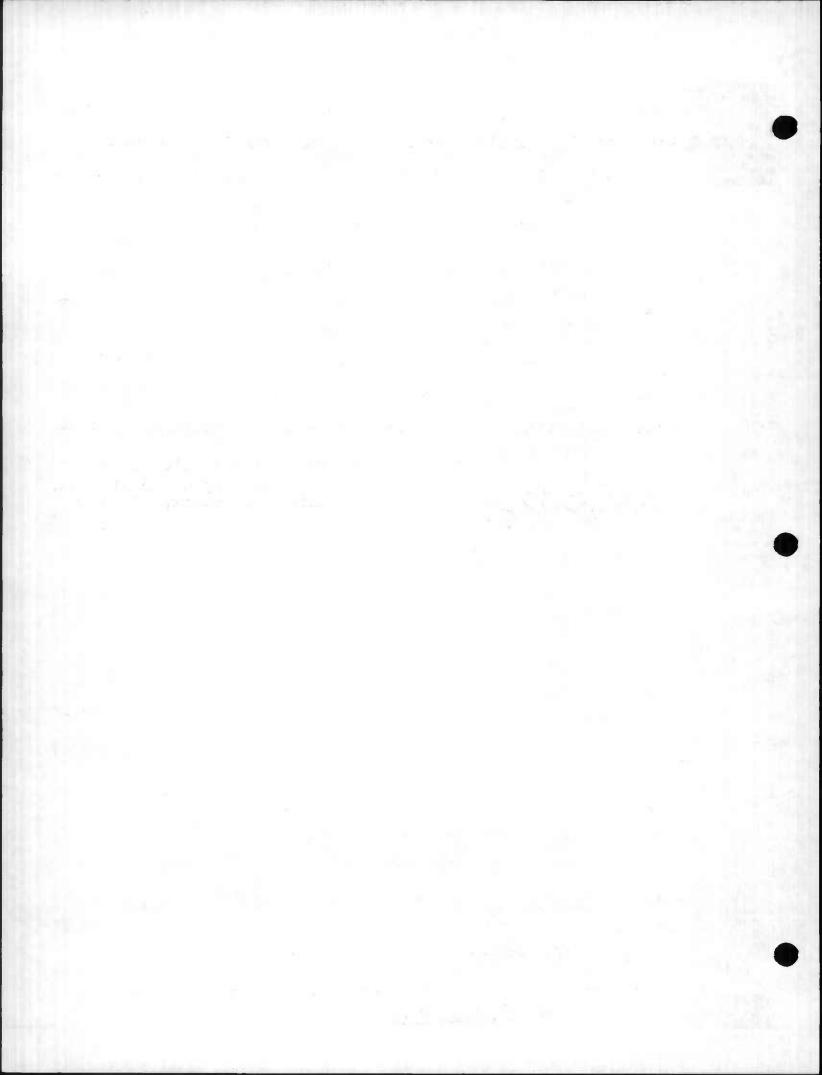
28d. Dascribe how injury occurred

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

1104 Healthway Dr., Salisbury, MD 21804

31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura JAN 12 1998 al Davidson Rarlall

29d. Data signad (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygierie ? HAKIM Certificate of Death ASTIM

	1.	Decedent's Na	me (First, Mi	ddla, Last)
Physician /Medical		Hakim	Shadi	Asim
Examiner	4a	Facility Name	(If not institu	tion, give s

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.
In: If item 27 is marked other than "natural", or the my or other traumate event, the Marical Examine my or other traumate event, the Marical Examine.

Depertment of Important: If any injury or page.

Physician /Medical

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or Attanding Physician: effer deeth. Director: After this certific

To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by the

certificate be executed physician and s the buriel-trans

Division of Vital Records,

Examiner

Physician/Medical

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Certification:

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Baltimore, Maryland 21215-0020

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Hakim Shadi Asim 4a Facility Name (If not institution, give street and number)

Director

Funeral

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Completed

915 HARLEM AVE

5. Social Security Number 6. Sex 1 M 2 ☐ F 215-70-2591

7. Age (In vrs. last birthday) Yrs 35

BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours

 Birthplace (State or Foreign Country) Maryland

Year

20, 1998

4c. County of Death

3. Time of Death

9:15P.M.

10d. Inside City Limits

1 Ves 2 No

Usual Residence of Deceden 10a. Stata 10b. County 10c. City. Town or Location

Maryland Baltimore

10f. Zip Code 10g. Citizen of Whet Country? 21217 USA

2. Date of Death

JANUARY

8. Data of Birth (Month, Day, Year) 08/16/62

Month

4b. City, Town, or Location of Death

10e. Street and Number 2037 McCullough Street

1 Never Married 2 Married 3 Widowed 4 Divorcad

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Dates:

 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - Amarican Indian. Black, White, etc. Black Specify:

15. Decedent's Education (Specify only highest grade completed) Collega (1-4or 5+) Elemantary/Secondary (0-12)

16e. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier

16b. Kind of Businass/industry Retail Sales

17. Fethar's Name (First, Middla, Last)

Howard Stewart

Catherine Marie Stansbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) Pamela G. Carey/Sister

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

1021 West Cross St., Baltimore, Maryland 21230 20b. Place of Disposition (Name of cematary, crematory or othar place) Metro Crematory, Inc.

20c. Location - City or Town, State Date 01/28/98 Baltimore, Maryland

21. Signature of Funerel Sarvica Licensaa

Derrick C. Jones Funeral Home, 22. Nama and Address of Facility 4611 Park Heights Ave., Baltimore, Maryland

18. Mother's Name (First, Middle, Maiden Surnama)

23a. Part 1. Enter the diseasa, or complications that caus shock, or haart failure. List only one cause on the

tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Durchot h) occasion

21215 Approximate Interval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Dua to (or as a consequance of):

art II. Other significant conditions contributing to deat	h but not rasulting In tha	undarlying cause	given in Parl

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to

completion of cause of death?

28. Placa of Daath (Chack only one)

1 Yas 2 No 15 Yes 2 No

25. Wes case referred to medical axaminer? YYes 2□ No

27. Manner of Daath

5 Panding investigation 1 Natural 2 Accident 6 Could not be determined

1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 120/78

28b. Time of 2112M

Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) STREET 28c. Injury et Work? 1 Yes

28d. Describe how Injury occurred

3 Suicide 28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Subject Stort

281. Location (Street and Number or Rural Route Number City or Town, State) 9:15 Harley

(Check only one) 29b. Signature and title of cartifian

29a. Certifier

29c. Licansa number

29d. Date signed (Month. Dav. Year)

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O.C.M.E.

JANUARY 21,1998

30. Nama and address of person who complated causa of daath stam 23a) (Type, Print)

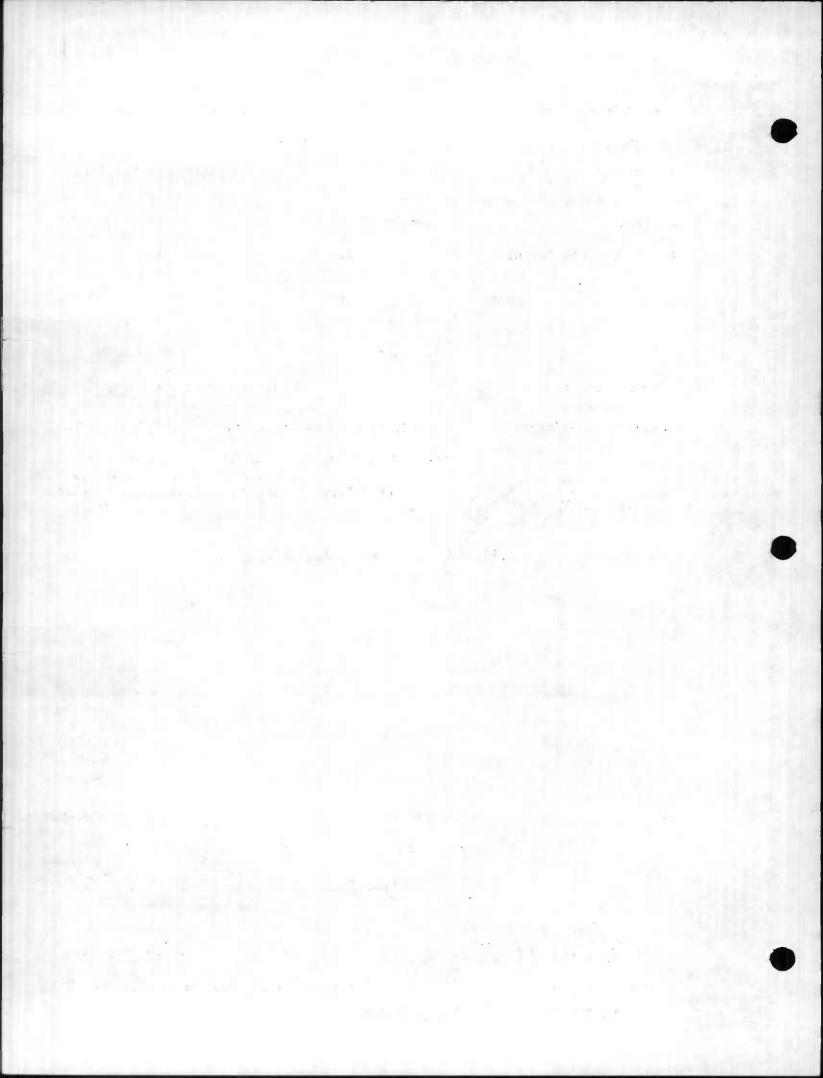
THEOURE MIKIN 31. Date filed (Month, Day, Year)

JAN 27

111 Penn Street, Baltimore, Maryland 21201

State Registrar 92. Registrar's Signature

7/0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month 6:30 P.M. Keith Adrianson, Sr. 1998 Januar 22 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 10XM 20 F Yrs. 310-38-8103 60 24, 1937 Indiana Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Anne Arundel Glen Burnie 1 Yas 2 No 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 7900 Benesch Cicle Apt. 767 21060-7926 USA 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Bace - Amarican Indian Black, Whita, atc 1 Navar Marriad 2 Marriad 1 ∑ Yas 2 □ No If Yas, Giva Yaar or Dates: 1956-60 Specify: White 1 ☐ Yas 2 ☐ No Spacify: 3 Widowad 4 Divorced 15. Dacedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Disabled N/A17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Dee B. Adrianson Norma Wilson 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Marlene Hartlove/Executor P.O. Box 1532 Pasadena, MD 21123 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) Metro Crematory, Inc. 01/26/98 Baltimore, MD 21. Signatura of Funary 19 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. Dawn F. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximata Intarval Batwaen Onset and Death Immadiata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseasa or injury Dua to (or as a consequence of): that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? t ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ms him tive disease 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy 1 ☐ Yas 1 Yas 2 No 2 No 25. Was cesa raferrad to medicel axaminar?

Physician /Medical **Examiner**

Physician

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Funeral

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item 27 is marked other than "naturel", or items 23e or 28a-f shor other traumatic event, the Modical Examinat must be inclined at

permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. In the Me

ettending physician for use es the bune á peen hes

Physician/Medical Examiner

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Certification: To

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this certificete or Attending Physician: death.

Division of Vital Records, P.O. Box 68760 To the Hospital or Attenditional within 24 hours efter death.

To the Funerel Director: A completely filled in by the fi

State Registrar

6 Could not ba 3 Suicida 4 Homicida (Check only

29b. Signature and titla of cartifiar

5 Panding

invastigation

1 ☐ Yas 2 No 27. Mannar of Daath

1 Natural 2 Accidant

Hospital:

28a. Data of Injury (Month, Day Yaar)

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Inpatiant 2 ER/Outpatient 3 DOA

1 ☐ Yas 2 ☐ No

28b. Tima of

28c. Injury at Work?

1X Cartifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as stetad.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred et the time, date and place, and due to the ceusa(s) and manner stated. 29c. Licansa number 29d. Data signad (Month, Day, Yaar)

Hospital.

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify)

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

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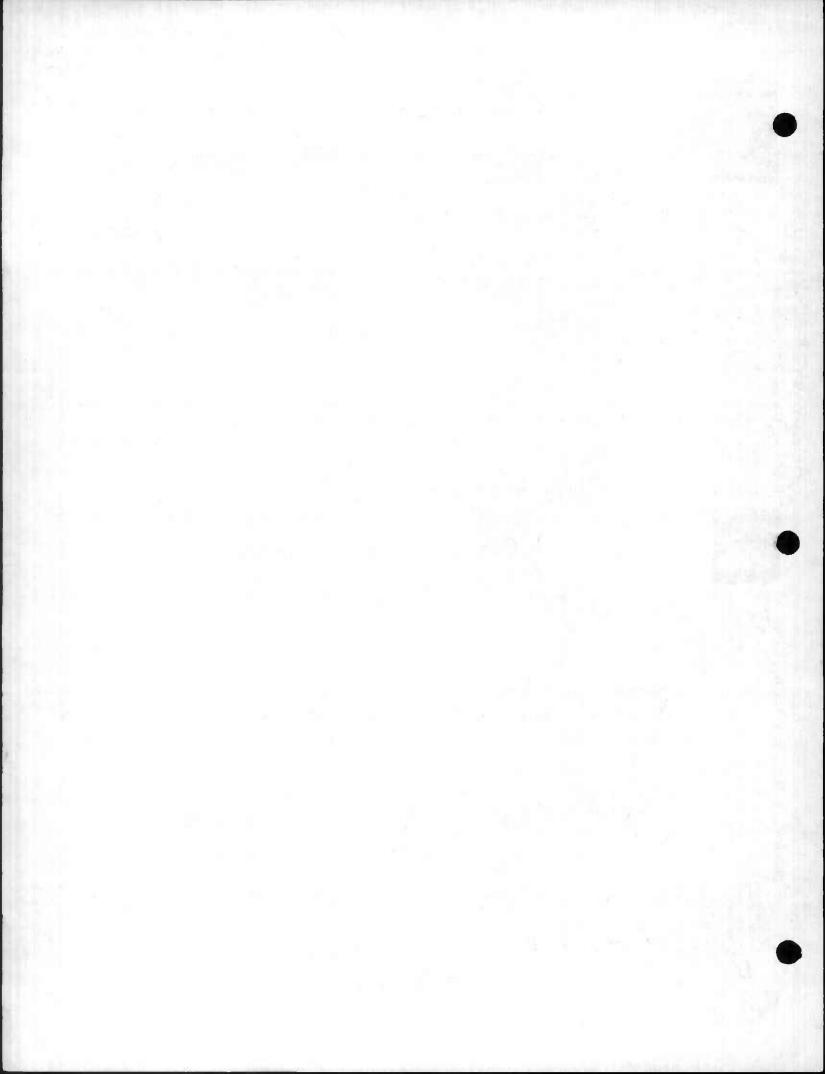
26. Placa of Death (Check only ona)

W. U 30. Name and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) Pridolf Titanji,
31. Data filad (Month, Day, Yaar)

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32. Ragistrar's Signatura Fully Davidson-Randolle



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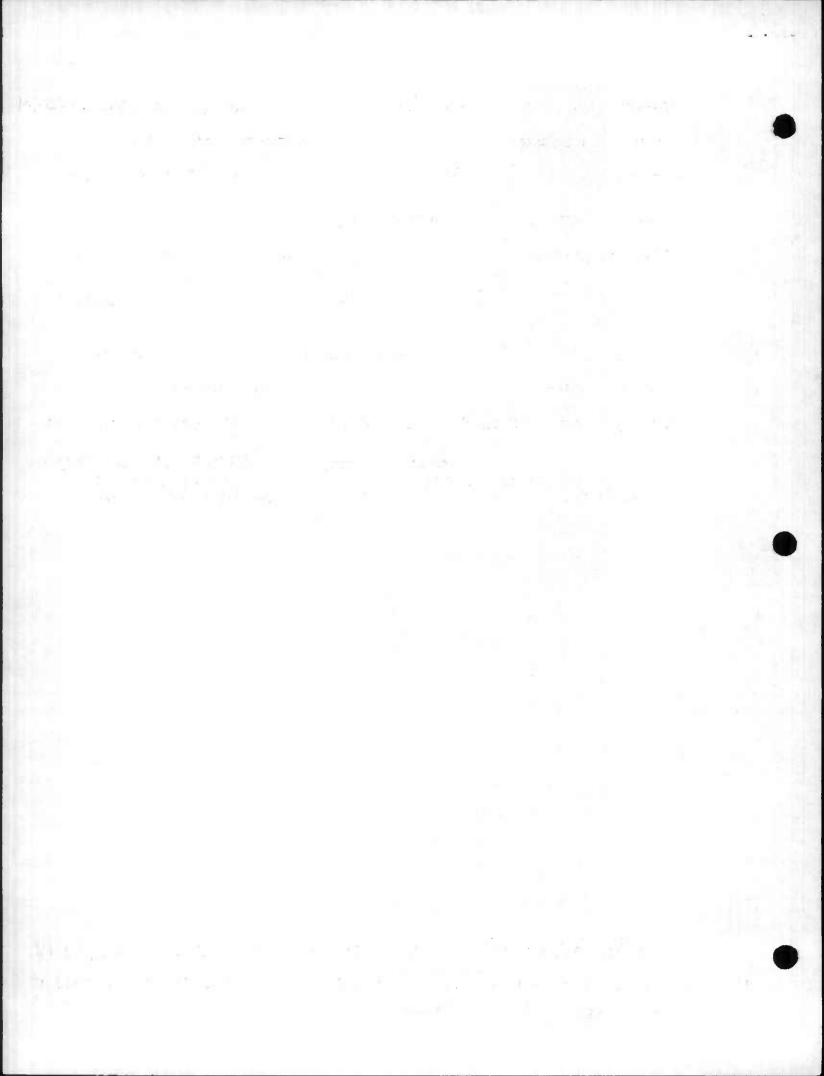
					, iana	Certificate		R	eg. No.	01/43
	Physici /Medi		1. Decedant's Name (First, Middla, Last VIRGINIA	St) M • - E-	4RTE	5		2. Date of Deat Month JANUAR	Day	1999 4: 23 A/
	Examir		4a. Fecility Nama (If not institution, give Church Home Hos)					Location of Death ore City	4c. County	
	Funeral Director		5. Social Security Number 6. S 215-12-8981		(In yrs. last bi	rthday) If Undar 1 Y Yrs. Months D		6. Dele of Birth	Year)	Birthplace (State or Foraign Country) Maryland
	Maryland -f show find at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Tov	m or Location	v			10d. Insida City Limits 1 □ Yes 2 □ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 5206 Catalpha Re	oad		10f. Zip Co		1	Og. Chizen of V	What Country?
020	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or ferna 23a or 28a-f show ord, the Medical Examinet must be notified at	by	11. Marital Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Datas:		13. Wes Decedent If Yes, specify	of Hispenic Origin? (Cuban, Maxicen, Pua No Specify:	Specify Yes or No- to Rican, etc.)		e - Amarican Indian, kk, Whita, atc.
21215-0020	filed within 72 h Hygiene. ther than "natu ent, the Med cal	Completed	15. Decedant's Ed (Specify only highast gra Elementary/Secondary (0-12)		168	Decedant's Usual O (Giva kind of work d life. DO NOT usa n Clerk / So	ccupation one during most of wo atired) ecretary			usinass/Industry
Maryland	\$ \$ \$ \$	To Be	17. Fether's Nema (First, Middla, Last) Howard Adam				Hele	ma <i>(First, Middl</i> a, A n E. Wehn	er	
Baltimore, Mar	of Heelth a litem 27 is other train		19a. Informant's Name/Ralationship (7) Mr. Henry T. Arte: 20a. Mathod of Disposition 1 M Burial 2 Cremetion 3 Company 4 Company 5 Contact (Specify	S / Husband	20b. Place comats	5. Mailing Addrass (Si 5.206 Catal) of Disposition (Nama only, cremetory or other cood Cemete	of r place)	Baltimo	re, Mar 20c. Location -	
Balti	parmit. Page Department of Important: If any injury or once.		21. Signeture of Funaral Service Licen	Michael E.		22. Nama and A	ddress of Facility lanford Roa	Leonar	d J. Ru	ick, Inc.
68760,	Physician /Medical Examiner	edicai Examiner	23a. Pert1. Entar tha disaasa, or compshock, or haart failura. List only of the second	a PERIPHE b. STAPHY	Dua to (or as a	CIRCULA consequence of):		+ILURE		Approximete Interval Between Onset and Death 6 HOURS
Box 68	death certifics e attending pl ed for use as t	Physician/Med		d						
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Records,	2 S D W	Completed	(R) CEREBRAL	INFAR	সেঠ	N		24a. Was a perform	n autopsy ned?	24b. Ware autopsy findings aveileble prior to complation of cause of death?
Vital B	T age	Be Com	ATRIAL F1 25. Was cesa rafarrad to medicel axaminar?	BRILLA	Mor	V	28. Placa of De	1 ☐ Ya		1 ☐ Yes 2 ☐ No
Division of V	ing Phys	Certification: To I	1 Yas 2 No 27. Manner of Death 1 Matural 5 Panding 2 Accidant invastigation 3 Suicida 6 Could not be	28a. Data of Injury (Month, Day) 28a. Place of Injury	y - At homa, fa		tnjury at Work? 1 Yas 2 No		w Injury occur	
ă	To the Hospital or Attent within 24 hours effer deet! To the Funeral Director: completely filled in by the		29a. Cartifiar 1 Certifying Phy	building, atc.	(Specify) my knowledge	a, daath occurrad at th	na tima, data and plac	City or Town	iusa(s) and ma	nnar as stated.
	To the Ho within 24 To the Fu completel	Medical	29b. Signatura and titla of certifiar	and mennar state	examinetion ar	29c. Lie	cense number	urrad et the tima, de	eta end place,	and dua to the cause(s) d (Month, Day, Year)
			MANA	1 orn Ran	/ MI	D	2502-	7- 1	NUAP	Y21 1999

State Registrar

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)
VITAY M. ABHYAWAR, CHURCH HOSPITAL, 100 N. BROMWAY, BALTIMORE
MB 21231

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Jan. 24 Day 998 **Physician** 8:15pm C . Blanchard Helen /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 831 Chestnut Tree Drive Cape St. Claire Anne Arundel If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 1 F 215 28 3095 Yrs. 80 Director Maryland June 19, 1917 Usual Residence of Decedent with the Manylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Anne Arundel Cape St. Claire 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. 831 Chestnut Drive 21401 permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, trailland Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Raca - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: g White 3 Widowed 4 □ Divorcad Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Mary M. Hipchen Meinhard George Janssen 10 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) daughter 831 Chestnut Tree Drive Cape St. Claire, Maryland Mary Corley 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 1/27/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Holy Cross Cemetery 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 remuseren 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** vitoreal Ademocarcinoma /Medical fmmediete Ceuse (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): The law requires that the death certificate be physical Due to (or as e consequence of): attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been si 24a. Wes en eutopsy Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) examiner?
1 Yes 2 No
27. Manner of Deeth
1 Natural Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funerai 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: A 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after To the Funeral Director complataly filled in Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner es steted.

I Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier Medicai

6

Baltimore, Maryland 21215-0020

Division of Vital Records. P.O. Box 68760.

31. Dete filed (Month, Day, Year)

Dr. Ensor Cole

29b. Signeture end title of cartifier

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

(Check only one)

32. Registrer's Signature which their doon fandall

900 Bestgate Road

29c. License number

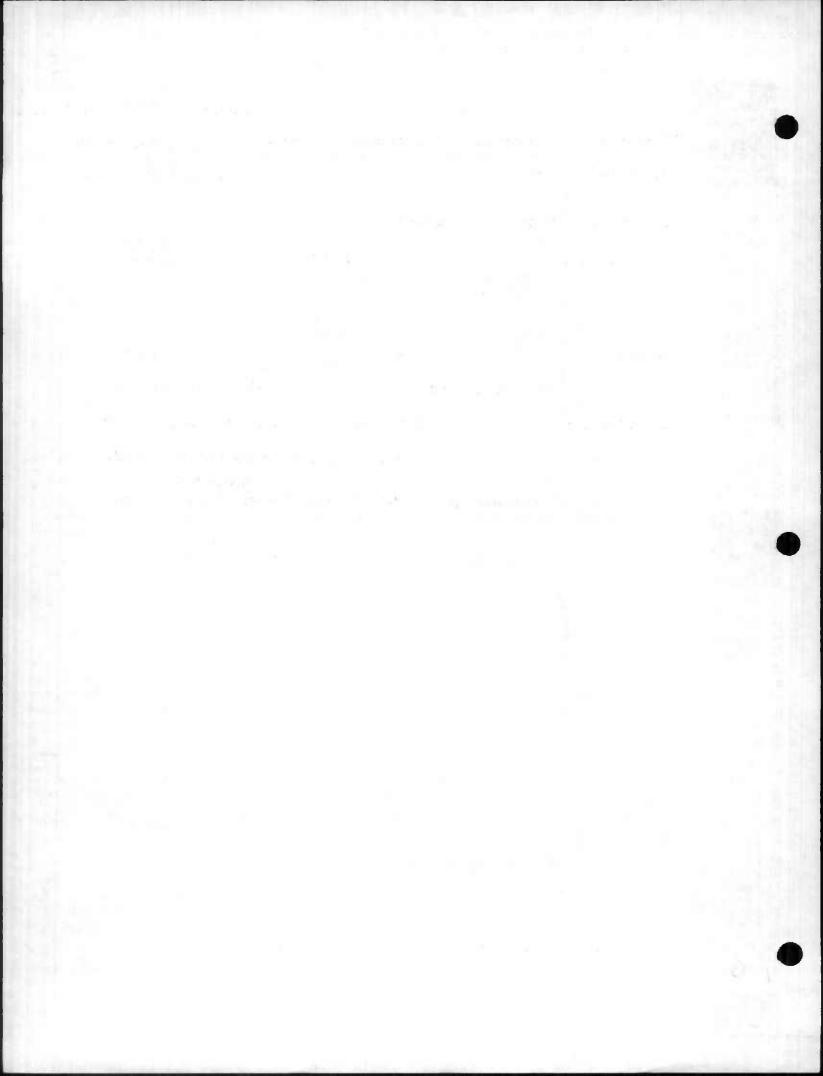
Annapolis, Maryland 21401

29d. Date signed (Month, Dey, Year) 26

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State of Maryland / Department of Health and Mental Hygienes

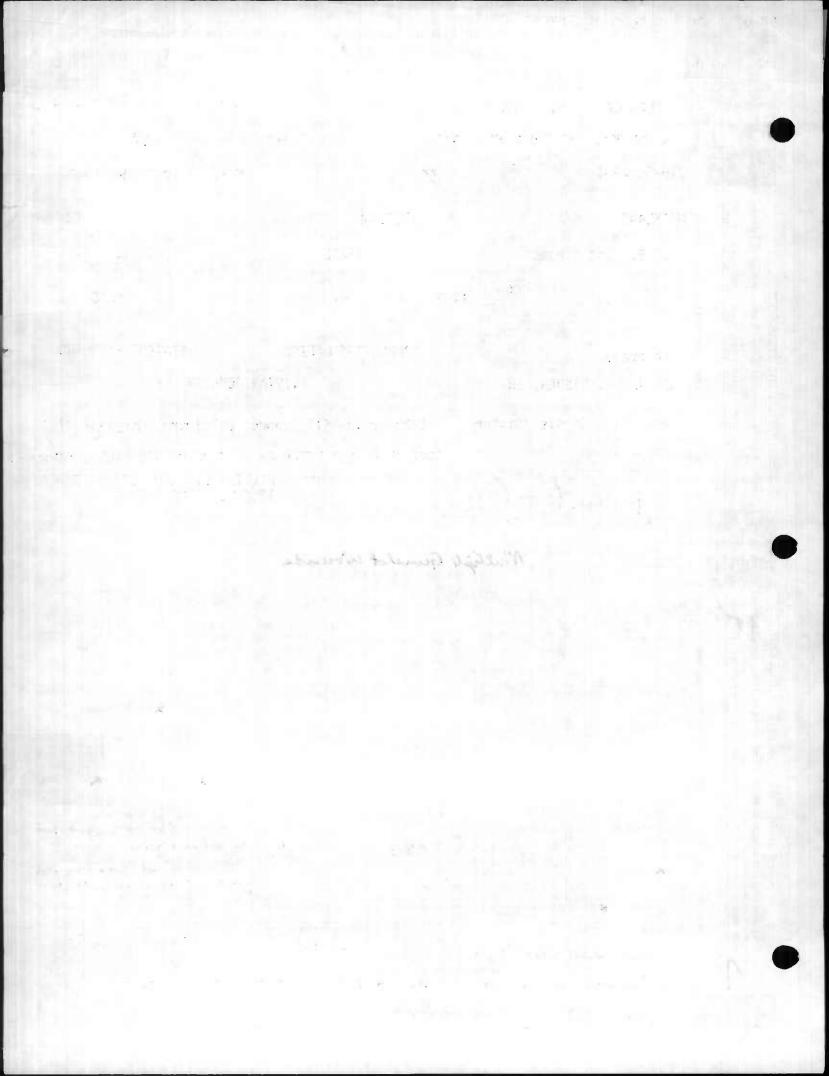
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or 28	Dire	10e. Street end Nu	mber				10f. Zip Coda			log. Citizen of W	het Count	ry?
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DHMH 16 Rev 6/95

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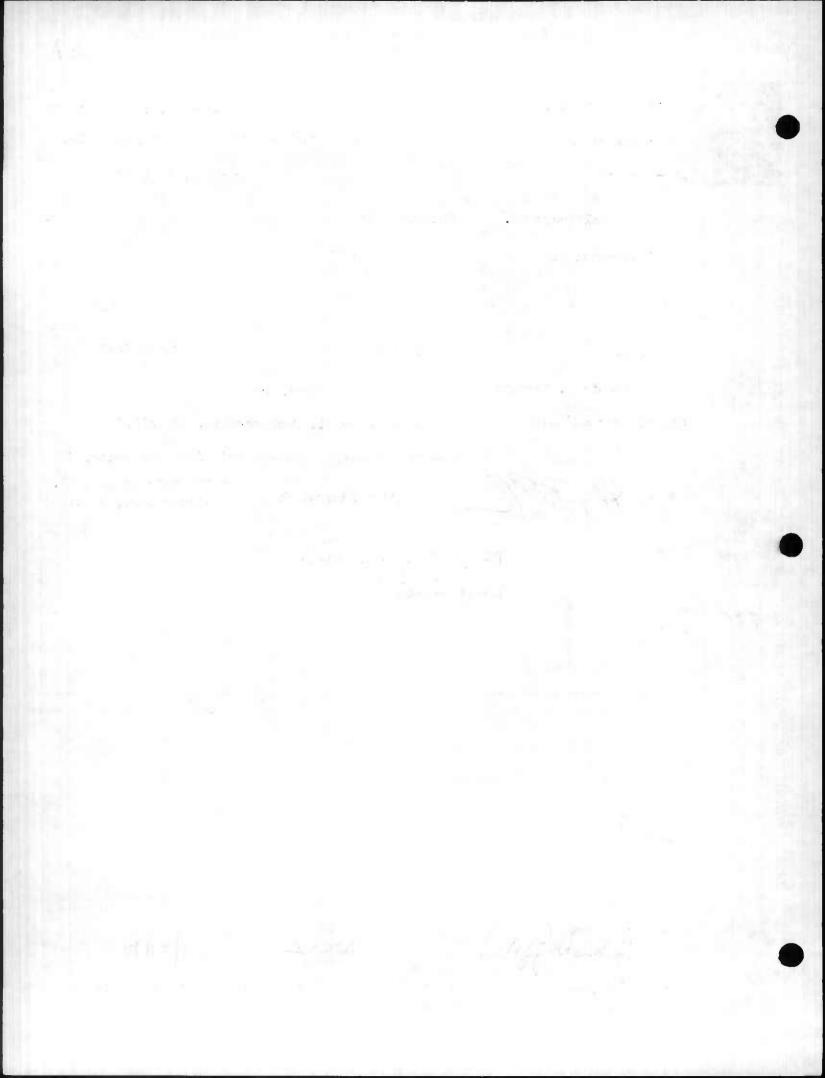
JAN 27 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 0 1 7 4 7

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27 is		Robert B	ouchet/ s	son		5F F	lazyd	awn I	1. Coc	key	sville,	MD	21093	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 19a, per F.H. G-755 1/27/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Sara Berkowitz Janvary 3:25 pm 1998 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, MAR. 11, 1917 5 Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M STAF 213-01-6564 80 Yrs Director MD Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 ☐ No BALTIMORE PIKESVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 238 1450 BEDFORD ROAD #216 21208 U.S.A. Funeral Nems! 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No WHITE by 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "rury or other traumatic event, II a Mer. Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **ABRAHAM** POTLOCK GERTRUDE BASS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JAY C. BERKOWIYZ / SON 12099 LONG LAKE DR. OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Depertment of Important: if any injury or BALTIMORE, MD MIKRO KODESH BETH ISRAEL 1/25/98 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Sol Levinson & Bros., 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner ar of Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Box 68760. Physician/Medical the Due to (or es e consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? this certificate 2010 1 Yes 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturai Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (m) lone mich

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

27

32. Registrar's Signature

Tulia Davidson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM:8 per F.H. Certificate of Death Item: I per Physician G-756 2/9/98 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** JAN. 21, GIZZELA 1998 12:11PM BAUM GIZELLA /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner BALTIMORE
If Under 24 Hrs.
Hours Min.

Min.

BALTIMORE
(Month, Day, Year)

MAR 22, 1926 3500 DEVONSHIRE DRIVE
5. Social Security Number 6. Sex N/A If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2□F Months HUNGARY 71 Director the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location d other than "natural", or items 23a or 28a-f ahow event, the Medical Examiner must be notified at Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Raca - Amarican Indian,
Bleck, White, etc. 3500 DEVONSHIRE DRIVE 21215 Funerai death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or Item
iny or other traumatic event, The Medical Engine 1 Yes 2 No
If Yas, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowad 4 Divorced Specify: þ WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 HOUSEWIFE OWN_HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TZVI **JACOBWITZ** YITTEL SCHWARTZ 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 HOOPER ST. #2F BROOKLYN, NY 11211 JULIA WEBER / DAUGHTER 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or once. 1/22/98 BALTIMORE, MD SHEARITH ISRAEL 22. Name and Address of Fecility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikes or redisease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, the failure. List only one and so neach line. 8900 Reisterstown Road Pikesville, MD 21208 Approximate Interval Between Onset end Daath **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner certificate be executed physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 98 ettending p JSB Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown Arthritis þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen 105 page 2 1 Yes certificate Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturai 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 I Homicide

Box 68760. Division of Vital Records, P.O. Medical Certification: To ne Hospital or Attending Pl n24 hours after death.

Baltimore, Maryland 21215-0020

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner as stated.

| Medicel Exeminer: On the best of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

S. SOBEL, MO TAMARA 31. Date filed (Month, Day, Year)

ZI Crossroads Drive #400 Owings Mills IMD

State Registrar

29a, Certifie

Registrer's Signature whip Davidson-Randoll

To the within Z

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev **Physician** Michael S. Baker 15 1998 January 8:06 AM /Medical 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner University of MD Medical Systems S Baltimore 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Min. Yrs 51 Director 213-46-0523 12/10/46 MD Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Med cal Examiner must be notified at 1 Yes 2 No Directo PA Adams Littlestown 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with 23 Fieldcrest Drive Funeral 17340 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mayes 2 mo
It Yes, Give
Yeer or Detes: 1965-67 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Multimedia Technician Bell Atlantic permit. Peges 1 and 2 should be file Department of Health end Mental Hyg Important: If flem 27 is marked other any injury or other traumatic event, page. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Laurence George Baker Jane Faye Everson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian M. Baker-Son 1315 linden Avenue Balto., MD 21227 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Cemetery 1-19-98 balto., MD Signeture of Funerel Service License 22. Name end Address of Fecility
Kaczorowski Funeral Home 1201 Dundalk avenue Baltimore, 1201 DUNDALK AVENUE BALU
23a. Pert1. Enter the disease or complications that disease the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause in each line. MD21222 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Cerebrovascular accident **Examiner** Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760 Due to (or es e consequence of) -The law requires that the death 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of ceuse of deeth? page 2 has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No this certificate Division of Vital Attanding Physician: diractor 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? 28b. Time of Certification: After t 5 Pending 1 ☐ Yes 2 ☐ No I Director: A death. investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide eftar 10 within 24 hours To the Funeral Completaly filled edical 29a. Certifie 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number P11768 January 15, 1998

Registrar

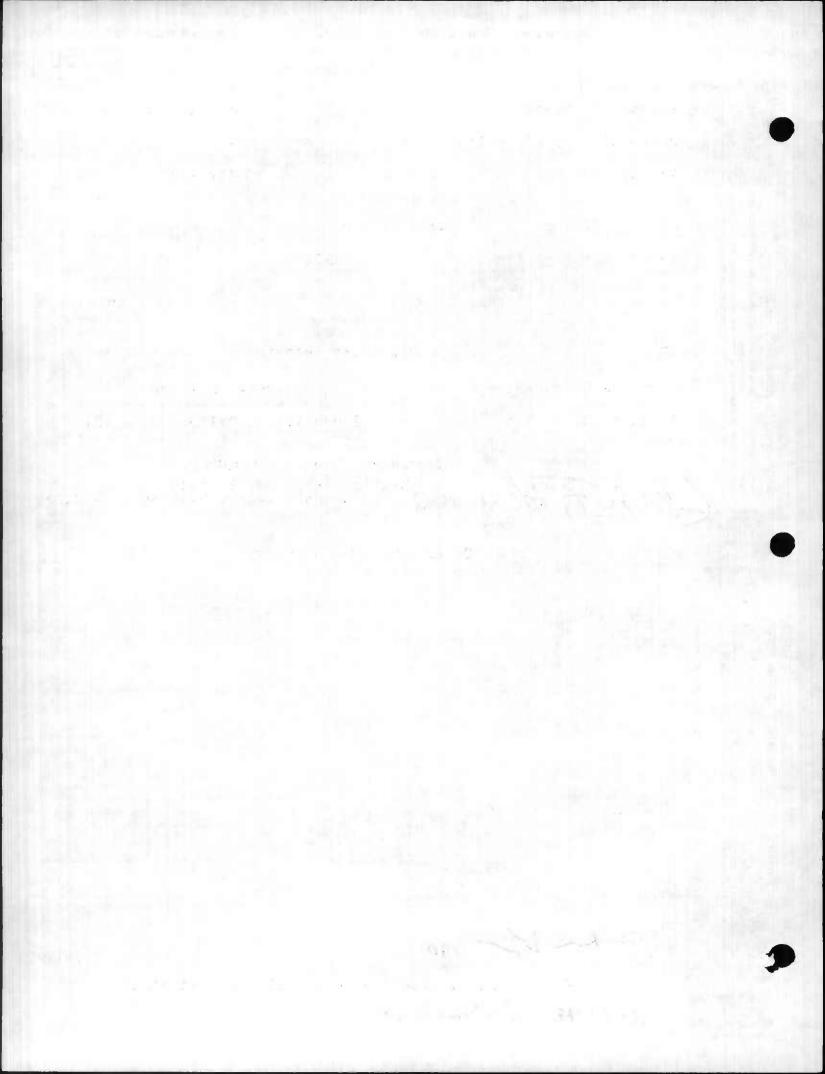
22 S. Greene Street Baltimore, MD 21201 Registrar's Signeture Davidson

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Joshua Leiffer MD

JAN 27 1998

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 35 Am atherine 24 01 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death TER RALTIMORE 7. Aga (In yrs. last birthday) Months Days Hours Min. Month, Day, Year) BAY VIEW MEDICAL CENTER N/A Birthplaca (Stata or Foraign Country) 5. Social Security Number Days 1 M 2 F Yrs. 213-84-6367 37 11/17/60 MARYLAND Usual Basidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida Cltv Limits N Yas 2 No MD BALTIMORE N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3202 MONDAWMIN AVE. U.S. 21216 11. Maritai Status 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black White atc. 1 ☐ Yas 2 XNo If Yas, Giva Yaar or Datas: X□ Navar Married 2□ Married 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 11 MEDICAL -0-NURSES AIDE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) JOHN WALLACE BROWNLEY RUTH PARRISH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 24 ESPERANZA COURT-PIKESVILLE, MD DEBORAH PRINGLE 21208 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1⊠ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) KING MEMORIAL PARK 1/28/98 RANDALLSTOWN, MD 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility ELIZABETH L. PHILLIPS DECIN CESP Veretta 1721-27 N. MONROE ST.-BALTO. MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immediata Causa (Final disaasa or condition resulting in daath) a Wasting Syndrome 3 months Due to (or as a consequence of): Colectony small bowel rerection end Cartial Dua to (or as a consequence of): noisintrol. Difficile colitis Dua to (or as a consaquanca of): years Immunadeficiency Syndrome Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Director

Funeral

þ

Completed

Be 2

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours affer to Deperment of Health end Mentel Hygiena. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examples once.

with the Marylend

death v

The lew requires that the death certificeta be axecuted ettending physician end for use es the burial-transit signed by the e Sec i director, pege or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Certification:

Physician/Medical Examiner

δ

Completed

Be

2

Medical

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Diseasa or Injury that Initiated avents rasulting In daath) Last

Herper rimplex ecophagitis

brackiel artery aneurying 5kin NECTOSIS cellulitis Sun

25. Was casa rafarred to medical examinar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yas 2 No 27. Manger of Daath 28a. Data of Injury (Month, Day Year) 5 Panding invastigation

1 Natural 2 Accidant 6 Could not be datarmined 3 Suicida 4 | Homicida

an

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

24a. Was an autopsy performed?

1 ☐ Yas 2 1 No

1 Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29b. Signatura and titla of chirt lin

29a, Cartifian

(Check only one)

29c. Licansa number 147557 29d. Data signed (Month, Day, Year) 1241

24b. Wara autopsy findings available prior to complation of cause of death?

1 ☐ Yas 2 No

21205

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Stephen Villano

Johns Hopkins Horpital, Ross 1159, 720 Rotland Ave, Baltmor, MD

Registrar

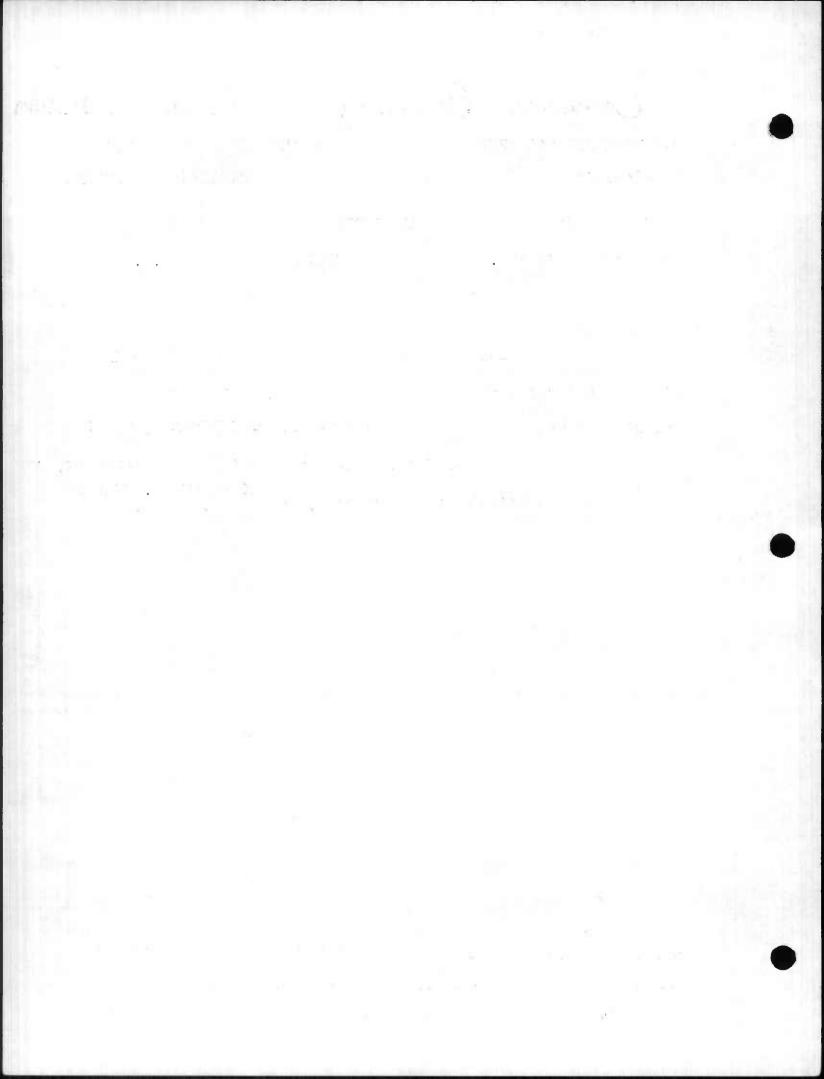
31. Data filed (Month, Day, Yaar) JAN 27 1998 32. Registrar's Signatura Sicha Davidson-Randalle

DHMH 16 Rev 6/95

death.

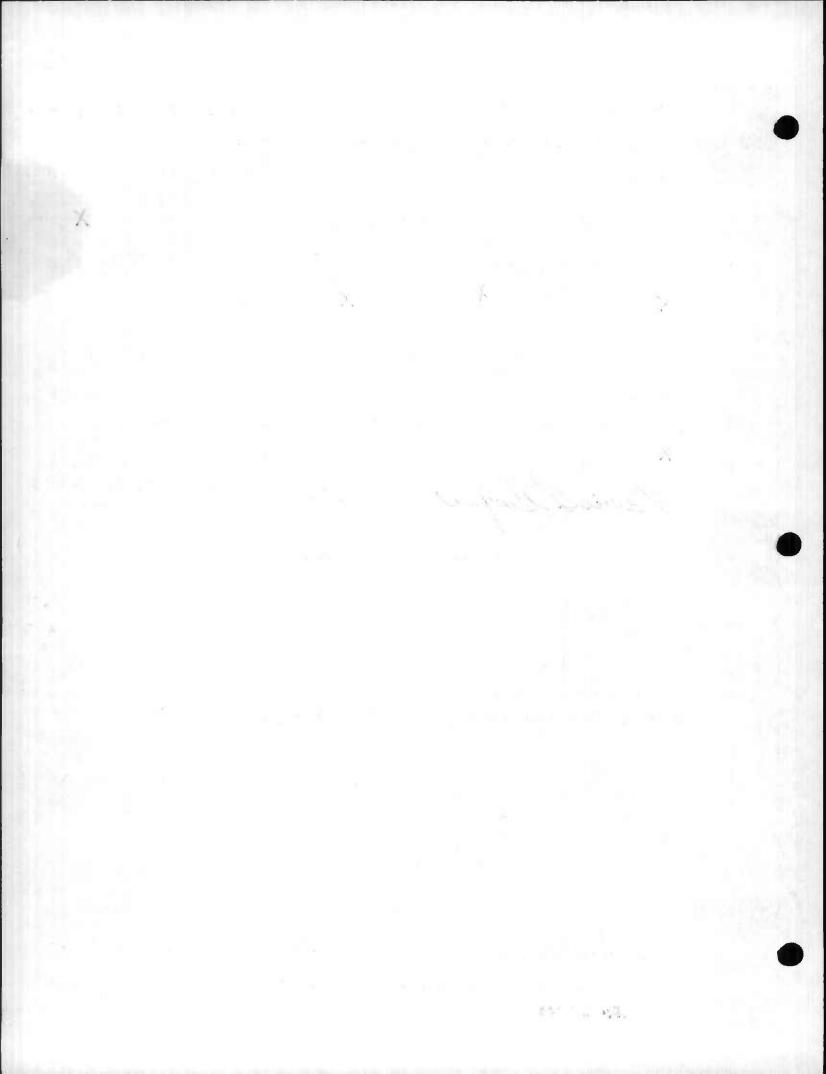
24

after death Director:



State of Maryland / Department of Health and Mental Hygiene 98 0 | 752

a. Facility Name (If not institution, give CONTROL OF	AVENUE 12. Wes Decedent Evarmed Forces? 1 Yes 2 7 8 AVENUE 12. Wes Decedent Evarmed Forces? 1 Yes 2 7 8 If Yes, Give Yeer or Dates: ucetion fe completed) College (1-4or 5+) N/A (SON) Removel from State	(In yrs. lest is 85 in 10c. City, To BAI) var in U,S. 20b. Plece ceme MT. GWY	birthday) Yrs. own or Locatio LTIMOF 13. Was if Yes 1 yes 6e. Decedent's (Give kind tife. Do N DOMES 7 19b. Mailing Ad 3 2 4 II 19 of Disposition of Property, cremator ZION NN 22. Nar LEV 4 5 7	PRE Of. Zip Code Decedent of I s, specify Cub Yes 2 No S Usual Occup Of work done TIC Wo ddress (Stree LCHES' n (Name of ry or other pla TIC WIST THE CHES' THE CHES	PALT If Under 24 H Hours M 21218 Hispanic Origin? ben, Mexicen, Pu Specify: Ipation during most of v ed) ORKER 18. Mother's N MARY It end Number or TER AVI ace) TERY 1 ess of Facility GWYNI RK HEIC	(Specify Yes or Nerto Rican, atc.) working ALBERT Rural Route Num. E. BAL Dete /16/98 N FUNER GHTS AV	Dey /Z ath 4c. County N / irth Year) 2 10g. Citizen of V U.S. Co 14. Race Blee Specify 16b. Kind of Bi PRIVAT e, Maidan Suman A GREEN ber, City or Town, TO., MD. 20c. Location BALTIM AL HOME	9. Birthpleca (State or For NORTH CARO 10d. Inside City Lir 1 Yes 2 C Whet Country? OF A. 20 - Americen Indian, ck, White, etc. WE BLACK usiness/Industry TE FAMILIES TO State, Zip Code) 21218 - City or Town, State MORE, MD. E 21215-639
a. Facility Name (If not institution, give Social Sacurity Number 6. Sa 11 21 3 20 2574 Sual Rasidence of Decedent 10e. Stete 10b. County MD. N/A 10e. Street end Number 324 ILCHESTER 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest gred Elementary/Secondary (0-12) N/A 7. Fathar's Neme (First, Middla, Last) CECIL GREEN 9e. Informent's Neme/Rejetionship (7) NILLIAM DEMPSEY 10e. Method of Disposition 10e. Burial 2 Cremetion 3 February 11ementary Secondary 12ementary Secondary 13ementary Secondary 14ementary Secondary 15ementary Secondary 16ementary Secondary 17ementary Secondary 18ementary Secondary 19ementary	AVENUE 12. Wes Decedent Every Armed Forces? 1 Yes 20 f No If Yes, Give	(In yrs. lest is 85 in 10c. City, To BAI) var in U,S. 20b. Plece ceme MT. GWY	birthday) Yrs. own or Locatio LTIMOF 13. Was if Yes 1 yes 6e. Decedent's (Give kind tife. Do N DOMES 7 19b. Mailing Ad 3 2 4 II 19 of Disposition of Property, cremator ZION NN 22. Nar LEV 4 5 7	Under 1 Year on the property of work done of the property of the property of the property of work done of the property	PALT If Under 24 H Hours M 21218 Hispanic Origin? ben, Mexicen, Pu Specify: Ipation during most of v ed) ORKER 18. Mother's N MARY It end Number or TER AVI ace) TERY 1 ess of Facility GWYNI RK HEIC	CSpecify Yes or Nerto Rican, atc.) Working Lama (First, Middle ALBERT Rural Route Num. E. BAL Dete 16/98 N FUNER GHTS AV	inth 4c. County N/ irth 4c. County N/ I 4c.	of Deeth A 9. Birthpleca (Stata or For NORTH CARO) 10d. Inside City Lir 1 Yes 2 [] Whet Country? OF A. 20 - American Indian, ck, White, etc. 21 E FAMILIES The American Indian, ck, white, etc. 22 E FAMILIES The American Indian, ck, white, etc. 23 E FAMILIES The American Indian, ck, white, etc. 24 E FAMILIES The American Indian, ck, white, etc. 25 E FAMILIES The American Indian, ck, white, etc. 26 E FAMILIES The American Indian, ck, white, etc. 27 E FAMILIES The American Indian, ck, white, etc. 28 E FAMILIES The American Indian, ck, white, etc.
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nmediate Cause (Final isease or condition		•			ing, such as cerd	iac or raspiratory		Approximete Intervel Between
equentielly list conditions, eny, leading to Immedieta ause. Enter Undertying euse (Diseese or injury	b. Di	ue fo (or as	a consequenc	ce of):				
iat initieted events	c	ua to (or as	e consequence	ce of):				
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ad II. Other elanificant conditions as	ntributing to don'th but	not seculting	n in the contact	hula anua ai	tues le Best l	OSh Die	d tahaasa waa sa	antibute to the course of de
								3 Probably 4 Unk
								24b. Were eutopsy findin available prior to completion of cause of deeth?
						1□	Yes 2 No	1 ☐ Yes 2 No
5. Wes case referred to medical					26. Place of D	Deeth (Check only	one)	
1 Yas 2 No	Hospital: 1 Inpatient	2 ER/	Outpatient 3	DOA Ot	ther: 4 Nursing	Home 5□Res	sidence 6 Oth	ner (Spacify)
7. Menner of Deeth	28e. Dete of Injury	28h	b. Time of injury	28c. Inju Wo	ury et ork?	28d. Describe	how injury occur	rred
2 ☐ Accident Invastigation			N	M 1	Yes 2 No			
4 Homicide determined	28e. Plece of Injury building, etc.	/ - At home, (Specify)	, farm, street, f	factory, office				ber or Rurel Route Number,
9a. Certifier Check only one) Certifying Physical Exami	ner: On the basis of en	xeminetion e	ige, deeth occu end/or investig	curred et the ti gation, in my o	ime, date end ple opinion, deeth oc	ce, end due to the curred et the time	e ceuse(s) end ma , dete end place,	anner es steted. end due to the ceuse(s)
9b. Signeture and tille of certifier				29c. Licens	ise number		29d. Date signe	ed (Month, Dey, Year)
1/1/	5.				9363	,	JAN	12,1998
New Continues of passen who are	ompleted cause of dea	th (Itom 22	el (Type Deint)	1)	,,,,,		4 / 110	-1110
5.7.	. Wes case referred to medical axaminer? 1 Yas No Menner of Deth Neture Invastigation Neture Could not be determined 2 Accident Could not be determined 2 Certifier Check only Check only Could not be determined b. Signeture and this certifier	. Wes case referred to medical examiner? Menner of Deth Neture S Pending invastigation S Could not be determined Policy Could not be determined Policy Policy Policy Could not be determined Policy Po	Wes case referred to medical examiner? Menner of Deth Menture S Pending Invastigation S Could not be determined Check only one) Certifying Phyelcien: To the best of my knowler (Check only one) Certifier Certifier	The sulting in deeth lest Dua to (or as e consequence of the sulting in deeth) Lest Dua to (or as e consequence of the sulting in deeth of the under of the	The substitute of the substitution of the subs	Dua to (or as e consequence of): Dua to (or as e consequence of): Dua to (or as e consequence of to part or to the underlying cause given in Pert I. Dua to (or as e consequence of to part or to the underlying cause given in Pert I. Dua to (or as e consequence of to part or to the underlying cause given in Pert I. Dua to (or as e consequence of to part or to the underlying cause given in Pert I. Dua to (or as e consequence of to part or to p	Dua to (or as e consequence of): Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Comparison of the conditions contributing to death ceuse of Death (Check only Month) and Death Conditions contributing to death ceuse of Death (Check only Month) and Death Conditions ceuse given in Pert I. Condition of the condition	Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e

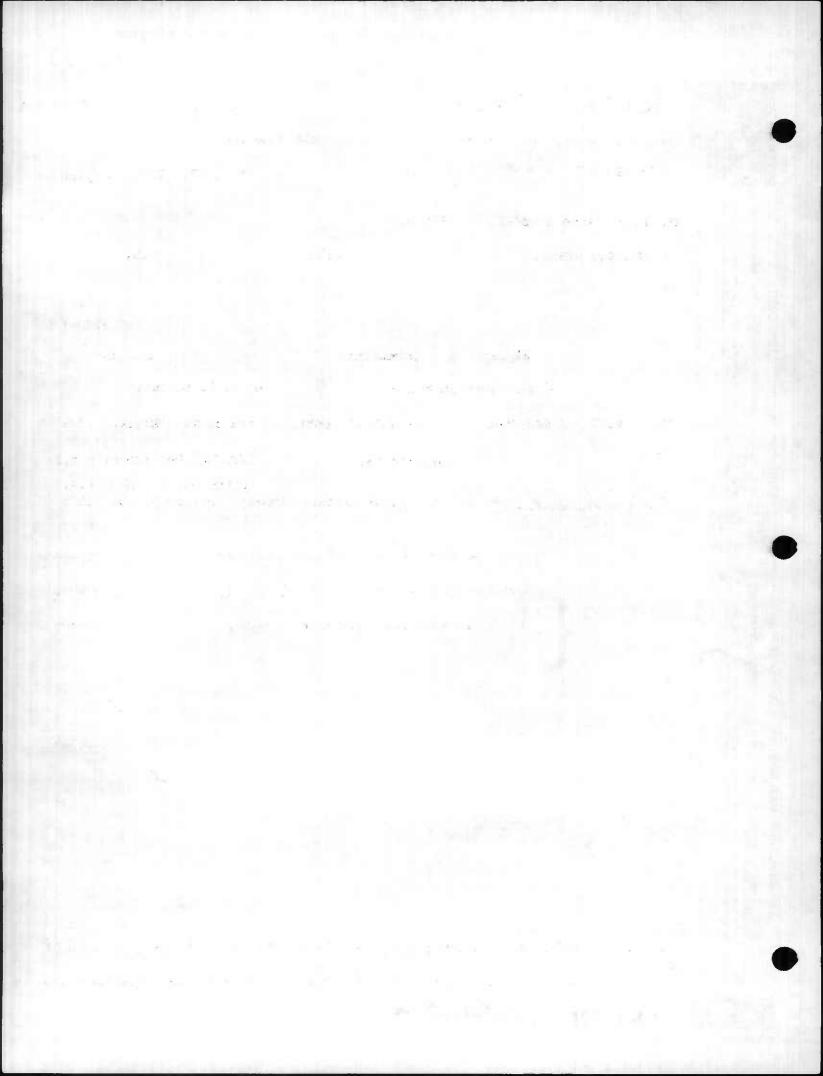


State of Maryland / Department of Health and Mental Hygiene 8 0 1 7 5 3

Certificate of Death Reg. No.

			Certi	ticate of	Death		Reg. No.				
Physician	1. Decedant's Nama (First, Middla, Last	COLE				2. Data of De Month	Day	Yaar 448 3: 45 PM			
· /Medical	4e Facility Nama (If not institution, giva	etreat and number)			th City Town	or Location of Dear					
Examiner	Harbor Honpi	1			Baiti		N	IA			
Funeral Director	5. Social Sacurity Number 6. Se 102 14 0407	7. Aga (In yrs. I		If Undar 1 Yaar Months Days	If Undar 24 H Hours M	in. 8. Data of Bi (Month, D. NOV • 2	rth ay, Year) 27, 1923	9. Birthplace (Stata or Foraign Country) Maryland			
	Usual Rasidance of Decedant						., 1525	Time y and			
death with the Maryland me 23e or 28e-f show I must be notified at neral Director	10a. Stata 10b. County Maryland Anne Ar		10d. Insida City Limit: 1 ☐ Yas 2 ☑ No								
vith the Ma to route be notified Director	10e. Street and Number		ltimore	10f. Zip Coda			10g. Citizen of What Country?				
23a or	29 Wallace Avenu			212			U.S	3.			
or the	11. Marital Status 1 Navar Married 2 Married 3 Widowad 4 XDivorced	12. Was Dacedant Evar in U, Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas:	If Y	is Decedant of H as, specify Cubs	lispanic Origin? an, Maxicen, Pu Specify:	(Specify Yas or Narto Rican, atc.)		e - Amarican Indian, ck, Whita, atc. White			
	15. Decedant's Edu	icetion	16a. Decedan	nt's Usual Occup	ation		16b. Kind of Bu	usinass/Industry			
should be filed within 72 hours af and Mantal Hyglane. marked other than "natural", or imatic event, its Medical Exam To Be Completed by I	(Specify only highast grad	Collaga (1-4or 5+) 2 years	(Giva kin lifa. DO Homem	nt's Usual Occup nd of work dona NOT usa ratired	during most of i	working	Otal	n Home			
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d 2 should be file th and Mantal Hy 7 is marked othe traumatic event To Be (ames Franklin	Wyble			Ethel P.	Barrett				
shound N and N and IN	19a. Informant's Name/Reletionship (T)	/pe, Print)	19b. Mailing	Addrass (Street	and Number or	Rural Routa Numi	ber, City or Town,	State, Zip Coda)			
1 and 2 Health a em 27 is	Carol Farley / d	aughter	29 Wal	llace Av	renue	Baltimo	re, Mary	land 21225			
Pages 1 a nent of Hea nt: If item iry or othe	20a. Mathod of Disposition 1 🔀 Burial 2 🗆 Cramation 3 🗆 f 4 🗆 Donation 5 🗀 Other (Specify)	damoval from Stata	tace of Disposition at the Disposition of Dispositi	ion (Nama of tory or other place	ce)	Data 1/26/98	Data 20c. Location - City or Town, Stata 1/26/98 Baltimore, Maryland				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mantal Hygiane. Important: if flem 27 is marked other than "natur any injury or other traumatic event, its Medical once. To Be Completed	21. Signature of Francisco Licens		22. N	Nama and Addra		Gonce	Funeral	Home P.A.			
	220 Part I Enter the disease or come							Md. 21225			
Dhysisian	23a. Part1. Entar tha disaasa, or comp shock, or heart failura. List only o	na causa on aach lina.	i. Do not antar	ina moda or dyir	ig, such as cere	nac or raspiratory	arrast,	Approximate Intervel Between Onset and Death			
Physician /Medical	Immediata Causa (Final	Oc. L	. P	n'ret	cu Ca	Luca		- days			
Examiner	disaasa or condition rasulting in death)	a. Puia to (or	r as a conseque	pirato	1 4			5 44 21			
je je	Electric Land	Acute Ey	000		7 days						
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E axe	Sequantially list conditions, if eny, leading to immadiata ceusa. Entar Underlying Causa (Diseese or Injury	2 days									
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aling page as		d.									
death o											
at the death of by the attendetached for u	Part II. Other significant conditions con	ntributing to death but not rasu	ulting In the unde	arlying ceusa giv	ran in Part I.	23b. Did	tobecco use co	ntributa to the cause of death?			
that the death ed by the atten detached for u						1□	Yee 2□ No	3 Probably 4 ☐ Unknown			
w requires that that is been signed by the should be detached by Physical By P							s an autopsy formed?	24b. Wara autopsy findings availabla prior to			
> 20 00 0000							Ollifor :	complation of ceusa of death?			
cartificata has irector, page 2						1 🗆	Yes 20 No	1 ☐ Yas 2 ☐ No			
ysician: The I s cartificata ha director, page To Be Com	25. Was case referred to medical				26. Place of I	Death (Check only	ona)				
ysicials cart direct	axaminar? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	ER/Outpetient	3□ DOA Oth	0.0	g Home 5 ☐ Ras		er (Specify)			
£ £ 8	27. Manner of Deeth	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			how injury occur				
ath. r: Aff	1 Naturel 5 ☐ Panding 2 ☐ Accidant Invastigation	(Monny Bay 1 day)	wijury	M 1 🗆							
tal or Attending P is aftar death. al Director: After t lad in by the funera Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide datarmined	28a. Place of Injury - At ho building, atc. (Spacify	oma, farm, streat	t, factory, office	540		28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29a. Cartifier 12 Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of exeminet and mannar stated.	wladga, daath o ion end/or inves	ccurred at tha tir stigetion, in my o	na, data and pla pinion, death or	ace, and dua to the courred at the time	ceusa(s) end me , dete end place,	enner es stated. end due to tha cause(s)			
o the of the omple	29b. Signatura and titla of certifiar			29c. Licans	a number		29d. Data signa	d (Month, Day, Year)			
- 5 - 0	Amir Quela	tiel, mo	2	AS 21	44 + 61	4-46	January	22,1998			
6	30. Name and address of person who co	b MO 1447	23a) (Type, Pri	int) pitel Ce	nter 30	101 S. Ha	noverst	Baltimore, MO 2127			
	Marchael and all	32. Registrer's Signat						-			

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month RAYMOND CLARK , JR. JANUARY 1998 8:30 PM /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY If Under 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) 8. Deta of Birth (Month, Day, Year) 9. Birthplece (Stata or Foraign **Funeral** Deys 1 M 2□ F 72 Director Yes 220-14-3037 Dec. 29,1925 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Madical Examiner roust be notified at 10d. Inside City Limits Montgomery Maryland Silver Spring 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2201 Briggs Road 20906 United States death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Giva Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Mental Hydiene. Important: If Itam 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Experient. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Willson Development Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown Corporation Carpenter 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumame) Be Raymond M. Clark, Sr. Marquerite Turner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2201 Briggs Road, Silver Spring, Maryland 20906 Catherine Clark / Wife 20b. Placa of Disposition (Name of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from State 4 Donetion 5 Other (Specify) George Washington Cemetery 1/24/98 Adelphi, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home San P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between **Physician** /Medical Immediate Cause (Finel GASTROINTESTINAL HEMDARHAGE disease or condition resulting in deeth) DAY Examiner Due to (or es a consequence of): Examiner ettending physician and for use es the bunel-trensit Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): signed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITIS Records, 24b. Were eutopsy findings eveilabla prior to completion of causa of deeth? Completed 24a. Wes en eutopsy parformed? 1 ☐ Yas 2 ₺ No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1€ Inpatient 2 ☐ EP/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 2 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and mennar stated. 29a. Certifier Medical (Check only one)

29c. License number

D23124

; 3416 OLANDWOOD, COURT.; OLNRY, MARYLAND 20832

29d. Date signed (Month, Day, Year)

Fanuary 22, 1998

State Registrar

29b. Signature end title of certifier

m.H

Dennis M. Hannon, Mo

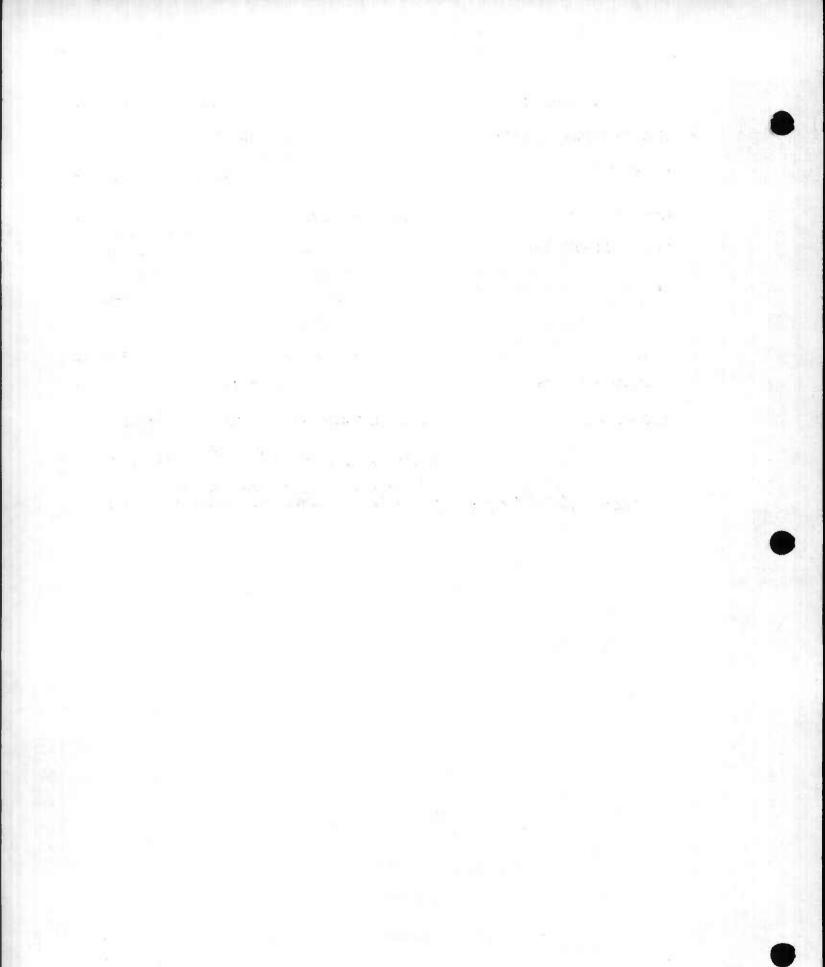
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1998 Julia Davidson

THE PROPERTY OF THE PROPERTY O

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 755

					Certifica	ate of	Death		Reg. No.			
Physic		Decedant's Nama (First, Middla, Las DOROTHY COUNK						2. Dale of De Month JAN	22, 19		3. Tima of Death	
/Medi Exami		4a. Facility Nema (If not institution, giva GOOD SAMARITAN HO			1		4b. City, Town, or I BALTIMOR		alion of Death CITY 8. Data of Birth (Month, Day, Year) AUG. 11, 1916 10g. Citizan of What Country? U.S.A. 11, 1916 12, 10d. Inside 12, 12, 13, 13, 13, 13, 13, 13, 13, 13, 13, 13			
Funeral Director		5. Social Security Number 215-12-0164 6. Se	9x 7. Age 7. Age 8.	(In yrs. lest bii	Yrs. If Uni	der 1 Yaer Is Days	If Under 24 Hrs. Hours Min.	(Month, Da			ca (State or Foreign	
yland Now		Usuel Rasidanca of Dacedent 10e. Stala 10b. County		10c. City, Tow	n or Location		1, 1010		I. Inside City Limits			
Mar Sh	ctor	MARYLAND N/A		E	BALTIMO	RE CI	ΓY			1 X Yes 2		
th with th	Funeral Director	10e. Street end Numbar 4700 HARFORD RO	DAD		10f.	Zlp Code	21214		-		n	
within 72 hours after death with the Maryland ane, than "natural", or items 23e or 28e-f show he Madical Evarener must be incirted at	by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedani Et Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Datas:		I.S. 13. Wes Decedent of If Yas, specify Cu		lispanic Origin? (S an, Mexican, Puart Specify:	pecify Yes or No o Rican, atc.)			C.	
"natural",	eted	15. Decedant's Edu (Specify only highest grad	ucation de completed)	16a.	Decedant's U (Give kind of	sual Occup work dona	ation during most of wor d)	king	16b. Kind of Bu	usinass/Indus	stry	
filed within Hygiene. ther than ent, the Me	Completed	Elamantary/Secondary (0-12)	College (1-4or 5+N/A	7		OT usa retired) TRATIVE ASSISTAN					ICE	
should be filed within and Mentel Hygiene. marked other than Imatic event, the M	To Be	17. Fether's Neme (First, Middle, Last) THOMAS RANDOLPH	H		18. Mother's Neme (First, Middle, Meiden Surnama) ROSETTA CARTER							
0 0 m	-	19a. Informant's Name/Ralationship (7) REED HUTNER	ype, Print)			ass (Straat ESLEY					oda)	
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permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funaral Sarvice License	- 1	- 8	22. Nama CALVII	and Addre	ss of Fecility		HOME	110.		
Physician / Medical Examiner unit of the principle of the	VMedical Examiner	Immediata Cause (Final disaasa or condition rasulting in daath) Sequantially list conditions, if eny, leading to immediate cause. Entar Undarlying Cause (Disease or injury lhet initieted avants resulting in daath) Last	. Bilal	due to (or as a due to (or es	consequence of	UNC 11):	alion Vase	elar	acció	dul	,	
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Hospital or 24 hours efte Funeral Dir etely filled in	edicai (29a. Cartifiar 154 Certifying Phy. (Check only one)	sician: To the bast of ner: On the basis of a and mannar state	xamination en	o, daath occurre d/or Invastigati	ed at tha tir	na, data and place pinion, deeth occu	, and dua to tha rred at the time,	causa(s) and ma date and placa,	innar as state and dua to th	ed. na causa(s)	
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8		30. Nama and eddrass of person who or 5670 The 1	emplated causa of dea	ath (Item 23a)	(Type, Print)	31RI	EKSH R, H	TRIPE	RANK 212	397		
Sta Registr		31. Date filed (Month, Day, Year)	Julia Davidon	's Signature	e		,					



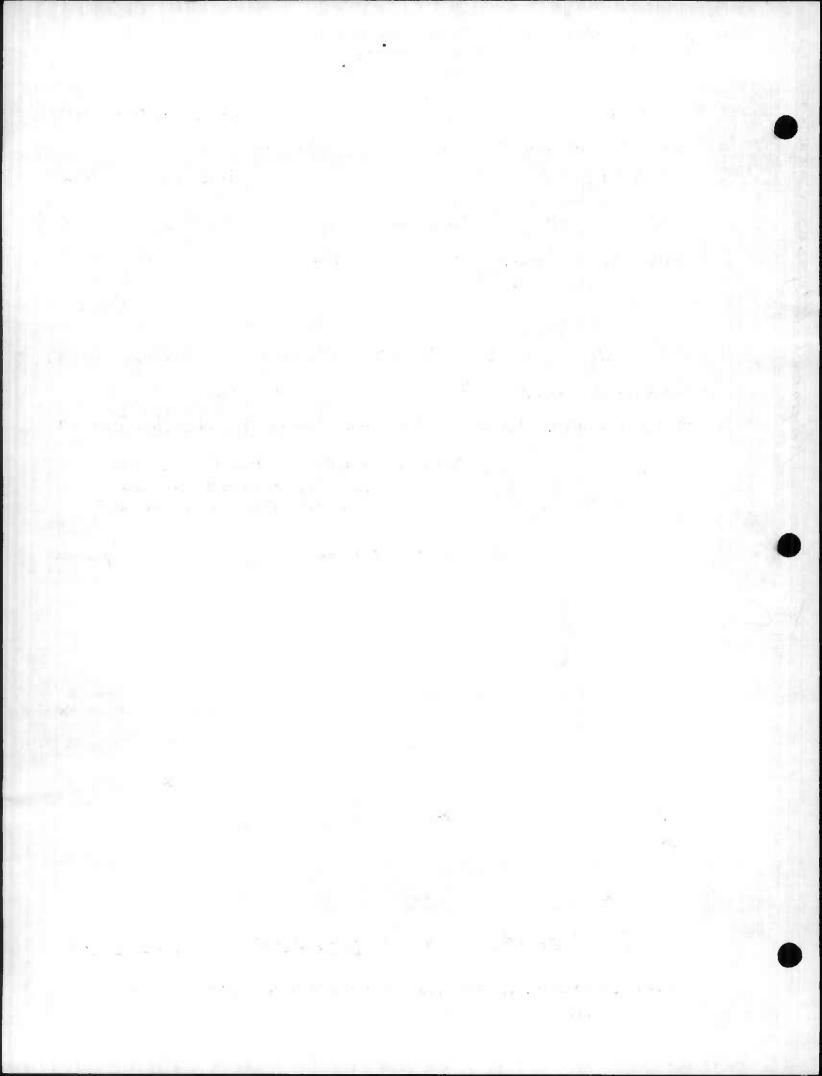
Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Von 23, 1990 4c. County of Deeth ARROLL /Medical 4b, City, Town, or Location of Death 6:34pm 4a. Facility Name (If not institution, give street and number) **Examiner** 'ommunity HUNDER 24 Hrs. | 8 Date 700 OCTORS If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min 212-40-0915 Yrs Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director IA MD N ('ARROLLTON V 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? M 238 5416 VENUE 20784 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 5 Maryland 21215-0020 2 1 No à BLACK 3 Widowed 4 Divorcad naturel. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 2 VRS Elementary/Secondary (0-12) Bymond STAFFING 12-TH GRADE NSTRUCIER GENCY 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be file ment of Health end Mental Hy ant: If Item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be CARROLL KAYMOND DIS HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20794 Department of Health er Important: if Item 27 is any Injury or other treu once. 5416 NEW CARROLLTON VERALON 851H ARROLL 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 1-29-98 BALTO, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE TUNERAL SERVICES 5151 BALTO. BALTO. NATL' PIKE 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart initure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Metrifatic concer 16 MOS **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 8 Due to (or as a consequence of) The law requires that the death certification signed by the el Part II. Other algnificant conditiona contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy 24b. Were autopsy findings Completed available prior to completion of cause of death? performed has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physicien: after death. Director: After this certifice director, 25. Was case referred to medical examiner?

127 Yes 2 □ No Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 FR/Outpatient 3 DOA funeral 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Jiffs of certifier 29c. License number 29d. Date signed (Month, Day, Year) (0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Pollock M.D., 8118 Good Luck Road, Lanham, Maryland 20706 82 Registrar's Signatura 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Yaar Roxanne C. Chisholm 25 JAN 1998 1:00 am /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice @ Mercy Hospital Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Days Director 551-78-3664 46 FEB 26, 1951 Maryland Usual Rasidence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural", or items 23a or 28a-f ahow injury or other traumatic event, the Madical Examiner must be inclined at N/A Baltimore N☐ Yes 2☐ No Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 2808 Windsor Avenue 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dates: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Naver Marriad 2 Married 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: Black Department of Health end Mentel Hygiene. mportant: if item 27 ie marked other than "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Computer Elementary/Secondary (0-12) College (1-4or 5+) Instructor/Trainer Information Systems 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be 2 should be fi end Mentel F Alfred Chisholm, Jr. 2 Jeanette Smith 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Chisholm, Jr./father 2808 Windsor Ave. Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pagas 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/26/98 21. Signature of Funeral Service Licansee 22. Nama and Address of Facility Cremation Society of Maryland, Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death **Physician** /Medical Immediate Cause (Final Metastatic Adeno Carcinoma diseasa or condition resulting in death) 13 months Examiner Due to (or as a consequenca of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be datact 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes 2 No 1 □ Yes 2 □ No Division of Vital To the Hospital or Attanding Physician: within 24 hours eftar death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. fnjury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29e. Certifier Medical completely 29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year)

D07930

301 St. Paul Pl., Suite 407 Baltimore, MD 21202

January 25, 1998

State Registrar

DHMH 16 Rev 6/95

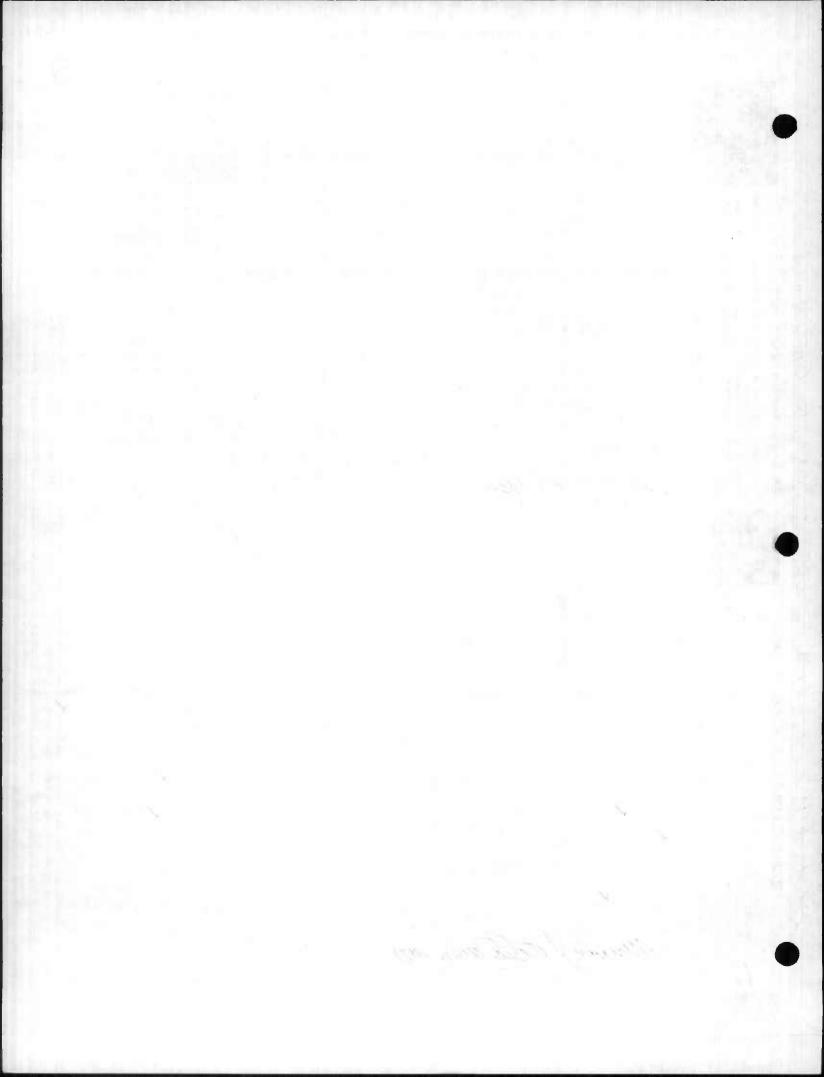
OXANNE Chisholm

1-25-78

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature Con 1. 19

Marvin Jack Feldman, M.D.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 3:43 Am William Burgess Cornell, Jr. 25 1998 anuary 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 9. Birthplace (State of Country) | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 1914 | 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1√2 M 2□ F Yrs. 215-03-6334 84 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Upland Road 21210 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ¼Yes. 2 □ No WW II If Yes, Give Year or Date& Korean 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Stock Broker Stocks & Bonds 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Burgess Cornell Betty Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniele H. Cornell/wife 4 Upland Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/26/98 Baltimore, MD 21. Signature of Funeral Sorvice Lice Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD21228 George E. MacNabb

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final adenocarcinoma with bone metastases disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Was an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician/Medical Examiner P.O. Box 68760 2 signad b Records, by Completed peen certificata Division of Vital Be Certification: To

Physician

/Medical

Examiner

MD

Director

Funeral

by

Completed

Funeral

Director

28a-f show

7 is merked other than 'natural', or items 23s or 28s-f sho traumatic event, its Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examinat

Physician /Medical

Examiner

William (2006)

the Hospital or Attending Physician: hin 24 hours aftar death. the Funeral Director: After this certifica within 24 hours aft To the Funeral Di completaly filled in

Medicai

4 Homicide

JAN 27 1998

29a. Certifier (Check only one)

State Registrar

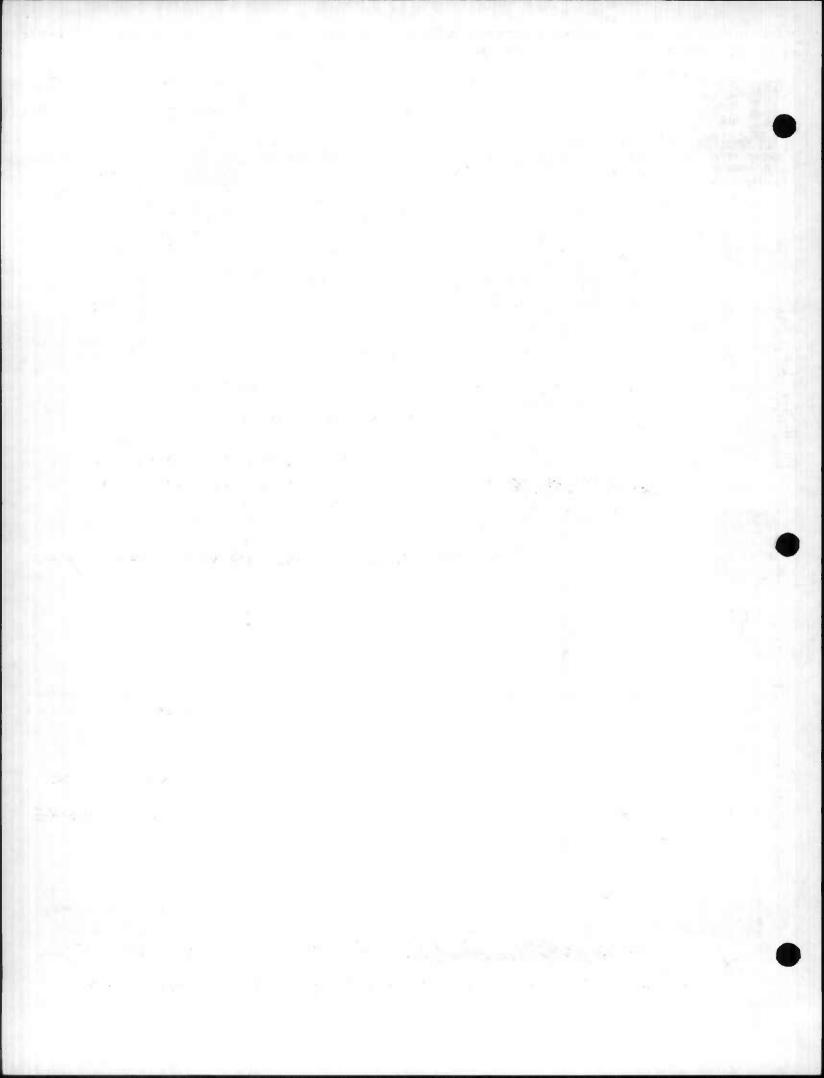
🕊 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed gauge of deeth (Item 23e) (Type, Print)

Falls Road, Lutherville, MD Laura M. Mumford, MD. 10755 31. Date filed (Month, Day, Year) 2. Registrar's Signature



Francis Carpenter

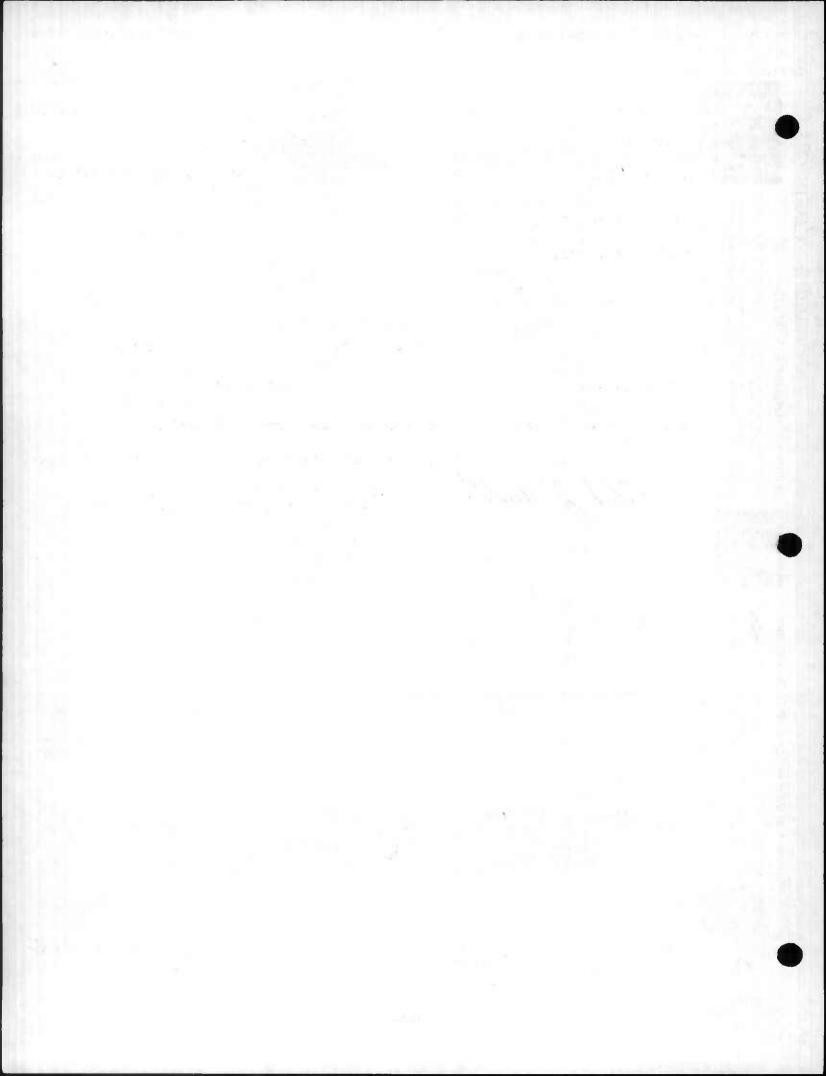
DHMH 16 Rev 6/95

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	Examir		4a. Facility Nama (If not institution, give		<u></u>			4b.	City, Town, or L				8	
			Mercy Hospital						Baltim					
	Funeral Director			Sex 7. Ag	a (In yrs. last 61	birthday) Yrs.	If Undar 1 Months	Yaar Days	If Undar 24 Hrs. Hours Min.	8. Data of Bi (Month, D June	23, 1936	9. Birthpli Count Penr	aca (Stata or Foraign ny) usylvania	
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	and 21215-0020 be illed within 72 hours after death with the Maryland ntal Hygiene. Ind other than "natural", or items 23a or 28a-1 show event, the Medical Examera must be notified at event.	Funeral Director	10e. Street and Numbar 1243 Dogwood Road				10f. Zip (10g. Citizan of V	hat Count	ry?	
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Baltimore,	permit. Pages 1 and 2 Department of Heelth i Important: if item 27 is any injury or other tre		21. Signature of Euneral/Service Lice	allendel	1	Ha	Nama and rdes	ty F	uneral	Home	P.A.			
			23a. Part1. Enter the disease or com- shock, or heert tailure. List only	plications that caused	tha daath. D	o not antar	tha moda	ge13 ot dying,	AVE.	or raspiratory a	olis, MD		1401 Approximata Intervel Batwaen	
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	9		30. Name and eddress of parson who	complated causa of di		e) (Type, Po	rint)	767	2 30	lain	Januar 236	J		
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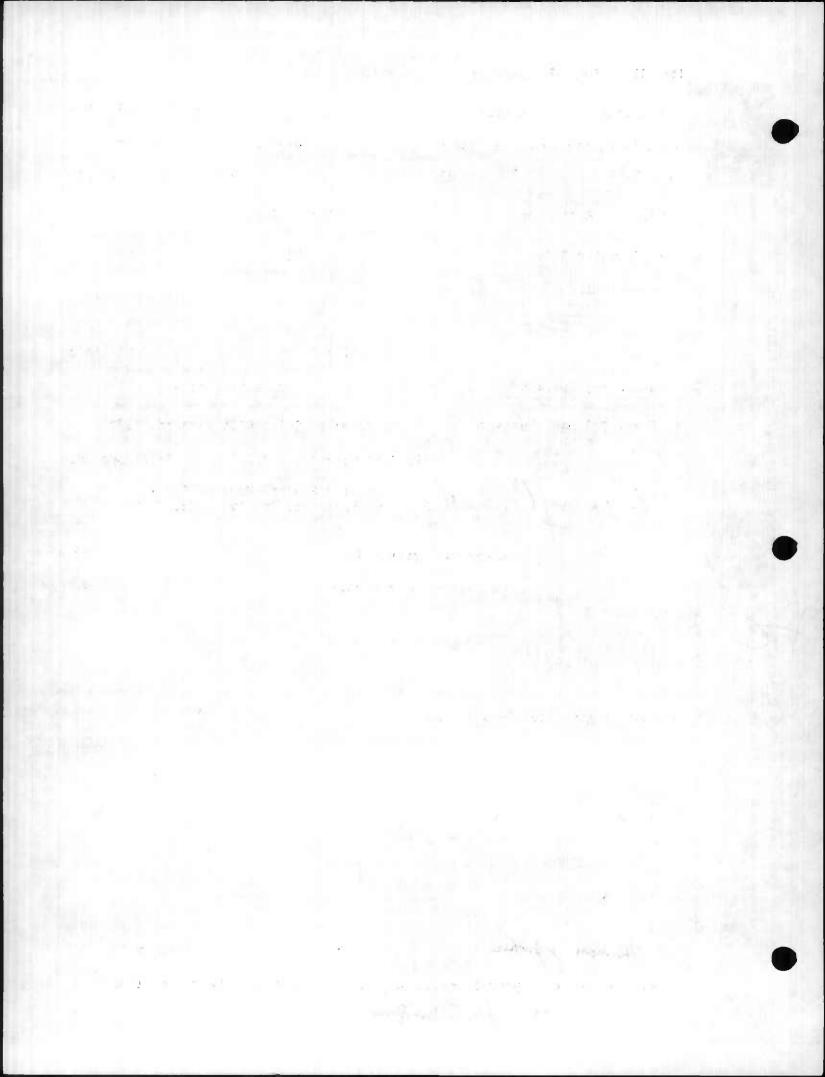
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death



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1. Decede	nt's Nama (First, Mid	Idla, Last)								Data of Das Month	Day	Year	3. Time	of Death	
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Md	Bal	timor	`e				Mid	dle R	iver				1□Y	as 2 No	
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	enry Fitzp				19h Mailir	a Addra	ss (Street			ninė Si Boute Numbe		wn, Stata, Zip Code)			
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FRank Coleman /husband 24 Yawmeter Drive BAltimore Md. 21220 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of company or other place) 20b. Placa of Disposition (Nama of company or other place)													wn, Stete		
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	P 1 L		10	111						ome of	Essex				
23a. Pert1. Enter the disease, or complications that caused the death and anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. Light any one cause on each line.												1	Approxir	nete	
shoo	k, or haart failura. Li	st controlle	cause on aach	lina.	The state of the	ar tirea iin	Joa or dyni	g, such es	Cardiac o	raspiratory ar	iast,	1	Intarval	Batween nd Death	
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2 □ A	icida 6 Coul	stigation d not ba	28e. Placa of I	niury - At h	oma, farm, etc			2		8f. Location /	Street and Numi	ber or Rure	ei Routa M	lumber.	
4□H	omicide date	rmined	building,	etc. (Speci	oma, farm, str fy)	uut, luoti	, o			City or Tov	m, Steta)				
29a. Certi	ier 1X Certify	ing Physic	ien: To the bes	t of my kno	wiedge death	occurre	d at the tin	ne. date an	d place, a	nd dua to tha	ceuse(s) end m	ennar as s	tated.		
(Chec	conly 2 Medica	al Examine	r: On the basis and mannar	of axamina	ation and/or inv	astigation	on, in my o	pinion, daa	th occurre	ed at tha tima,	date end place,	and dua to	the caus	ie(s)	
29b. Signe	ture end title of certif	fiar				2	9c. Licans	a number			29d. Data signe	d (Month,	Day, Yea	r)	
	Herman	20	where				RD 2	111			January	20.	1998		
	TACAL ACT	1 1					w 2.				- unual y	,			
30 Name	and address of person	on lyter ann	niated cause of	death /tte-	n 23el /Tune	Print\									
	and addrass of person						Drive	Bal	timor	e Marv	1and 21	237			



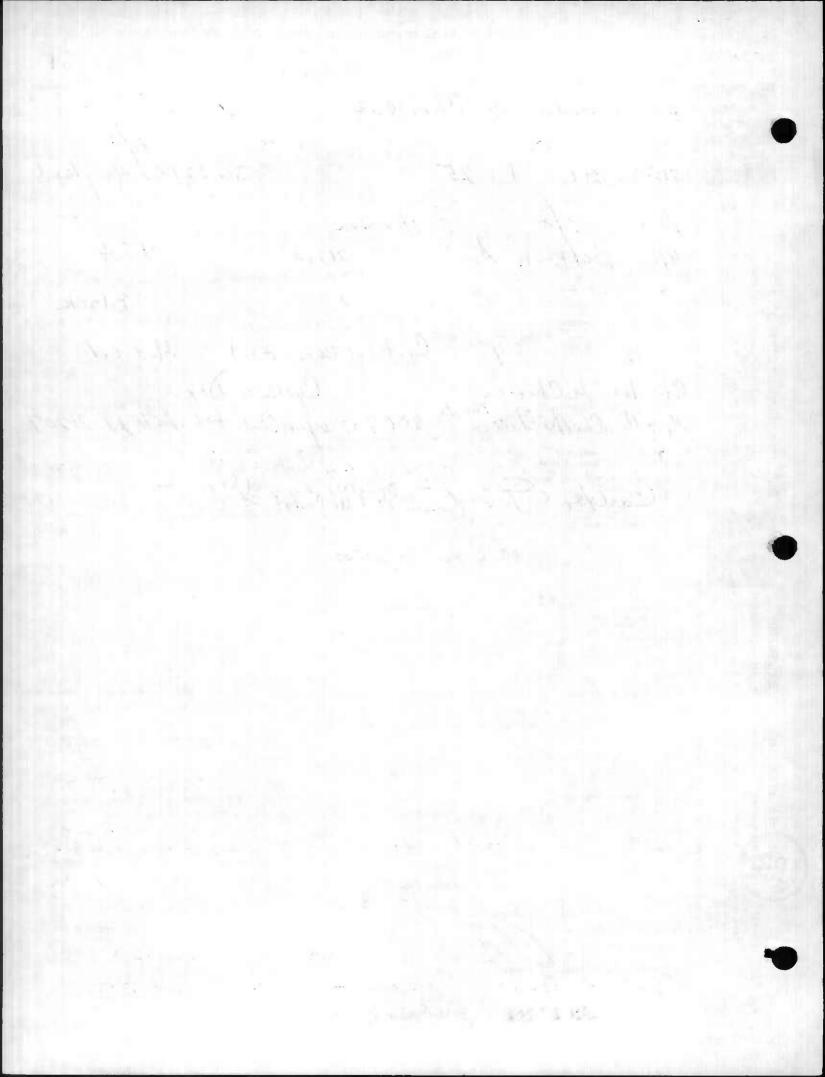
State of Maryland / Department of Health and Mental Hygiene

111 Penn Street, Baltimore, Maryland 21201

	RISCOE				Certific	ate of L	Death	Re	g. No.	U	1/61		
	Ph'ysicia /Medic	_	1. Decedent's Name (First, Middle, La Shawnde		riscos	-		2. Date of Death Month JANUARY	Day	Year	3. Time of Death		
ŶΓ	Examin	_	4a Facility Name (If not institution, given				b. City, Town, or	Location of Death	4c. County	7			
	Funeral Director		213-86-8200		last birthday) If Un Monti	nder 1 Year hs Days	BALTIMO If Under 24 Hrs Hours Min	8. Date of Birth	Year) 972	9. Birthp	place (Stata or Foreign try)		
	show	20	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ly, Town or Location					y	od. Inside City Limits		
	or 28a-f	Direct	10e. Street and Number	1	101.	Zip Code	7	10	Vhat Coun	itry?			
	ours after death with the Maryler st', or items 23e or 28e-f show Eraction must be notified	Funeral Director	4/02 Dalfe	12. Was Decedent Ever in U Armed Forces?	I,S. 13. Was De	2/2 ecedent of His specify Cubar	-	Specify Yes or No- to Rican, etc.)		e - Americ	ean Indian, etc.		
0000	72 hours after death with the Maryland natural; or items 23s or 28s-f show goest Energy or must be multished	P	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Yes	s 200 No	Specify:		Specify	DI	Black		
21215-0020	C " 6	Completed	15. Decadent's E (Specify only highest gn Elamantary/Secondary (0-12)	ducation ede completed) College (1-4or 5+)		Jsual Occupa work done d T use ratired,	luning most of wo	rking	16b. Kind of Bu	siness/Inc	Justry		
	be filed within tal Hygiene. d other than "	Be	17. Father's Name (First, Middle, Lesi	7	Crifica	ry Ca	18. Mother's Na	me (First Middle, N	Maiden Sumem	((A			
Maryland	2 should end Mer is marke	2	19a. Informant's Name/Relationship	Type print) Parents	19b. Mailing Addr	ress (Street e	and Number of R	a DiX urei Route Number,	City of Town,	Stete, Zip	Code)		
Baltimore,	permit. Peges 1 end Department of Haalth Important: If item 27 any Injury or other tr pnce.		20a. Method of Disposition 1 Burial 2 Cremation 3 E 4 Donation 5 Other (Speci	Removal from State	Place of Disposition (cometery, cremetory) 71 9 Mem 22. Name 20. O	(Neme of or other please and Address and A	Park	19,1998 1 Servi	Batti Climore	more	maryland		
To de	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal one cause on each line.	m. Do not enter the r	mode of dying	g, such as cardia			PIX	Approximate Interval Batween Onset and Death		
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Muchiple Due to (Frjur or as a consequence	of):							
ox 68760,	seth certificate be executed attending physician and for use as the buriel-trensit	n/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last	C	or as a consequence								
P.O. Box	thet the deeth cert led by the attandin detached for usa	Physician/M											
of Vital Records,	been sign should be	Completed by						24a. Was a perform		av	ara autopsy findings ailable prior to empletion of cause death?		
I R	The law ase has page 2	COU						1 2 Ye	es 2 No	14	⊋Yes 2□ No		
/Its	fetant The certificate rector, pay	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only on					
to	Physic and direction	2	1XXYes 2 No 27. Manner of Death	1 Inpatient 2L	ER/Outpatient 3□	DOA Othe	4 Indising	Home 5 ☐ Reside					
no	2 33	on	1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	Yes 2 Mo			101	iver		
ě.	or Attend Direction:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined.	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory)		165 2 140	28f. Location (St	ho - CLUS (OLLIS KA) pation (Street and Number or Flural Floute Number, or Town, Stete) OO (SUK KINK AVE)				
	To the Hearth within 24 hour To the Function complete y filled	edical C		nysician: To the best of my kno miner: On the basis of examine and manner stated.						annar as s	statad.		
	To the He within 24 To the Fu	₩ W	29b. Signature and title of certifier	111		29c. License	number	2	9d. Date signe	d (Month,	Dey, Year)		
-	- > - 0			11/1		OCIM	Œ	J	ANUARY	23,1	.998		
			30. Name and addrass of parson who	complated causa of death (Ital	m 23a) (Typa, Print)								

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 1. Dacedant's Nama (First, Middla, Last) Month Yaar Jan Maurice Corder JANUARY 20, 1998 2120 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Daath PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Yaar | If Undar 24 Hrs. 6. Sax 16 M 2 □ F 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Country) 2/27/1922 Kimbal, 9. Birthplaca (Stata or Foraign 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours Min 75 167 16 6974 Yrs. Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Delaware Milford 1 Yas XX No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 19963 Shawnee Rd. USA 12. Was Dacedent Evar in U,S. Armad Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 XYas 2 No If Yes, Give Yaar or Datas: W W II Specify: White 1 Yes X No Specify: 3 ☐ Widowed 4 ☐ Divorced 18e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Educetion (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Businessman, Land Developer Mobile Home 12 18. Mothar's Nama (First, Middle, Maiden Surnama) Annie Rae Kibler Corder 17. Fathar's Nama (First, Middla, Last) Maurice Cleveland Corder 19e. Informant's Name/Ralationship (Type, Priot). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Marie Collins Corder D. O. Borrow, Mild. Route Number, City or Town, State, Zip Code) P.O. Box c Milford, DE. 19963 20b. Place of Disposition (Name of camatary, cramatory or other place) $0dd \ \ Fellows \ \ Cemetery 1/24/98$ 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Milford, DE. 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility McKnatt Funeral HOme M00786 50 Commerce St. Harrington, DE. 19952 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onset and Death Immadiata Ceusa (Final disaasa or condition rasulting in death) thouselestic Condiovisculin Diserse eous Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of). Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Honknown 24b. Wara autopsy findings availabla prior to complation of causa of daeth? 24a. Wes an autopsy performed? 1 Yas 2 LA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 Languarient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

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Hygiene.

Pages 1 and 2 should be finent of Heelth and Mental Fint: if Item 27 is marked of

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Department of important: if any injury or

traumatic event, the Medical Examiner

filed within 72 hours eftar

Baltimore, Maryland

Director

Funeral

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Physician/Medical Examiner ata hes been signad by tha s page 2 should be datached to þ Completed Be

Box 68760. The law requires that the death certifical cartificata Vital or Attending Physician: director, o this funarai Division daath. after daati in by the Hospital • Funeral To the Hosp within 24 hou To the Fune completely fi

10

Certification:

Medical

State Registrar

31. Data filad (Month, Day Near)

Jeffuen

29b. Signatura and titla of certifiar

1 Yes 2 No

5 Panding Invastigation

6 Could not be datarmined

27. Manner of Death

1 Natural

2 Accident

4 | Homicida

3 ☐ Suicida

29a. Cartifian

30. Nama and assists of person who completed causa of death (Itam 23a) (Type, Print) 12 ther ton

28a. Data of Injury (Month, Day Year)

32. Ragistrar's Signatura

1 ☐ Yas 2 ☐ No

28c. Injury et Work?

1 Certifying Physictan: To the best of my knowladga, daath occurred at tha time, date end placa, and dua to tha cause(s) and mannar es stated.

2 Medical Examtnar: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29d. Data signad (Month, Gay, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

PRINC SALTSBURY

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify)

28d. Dascribe how injury occurred

Adia Davidson

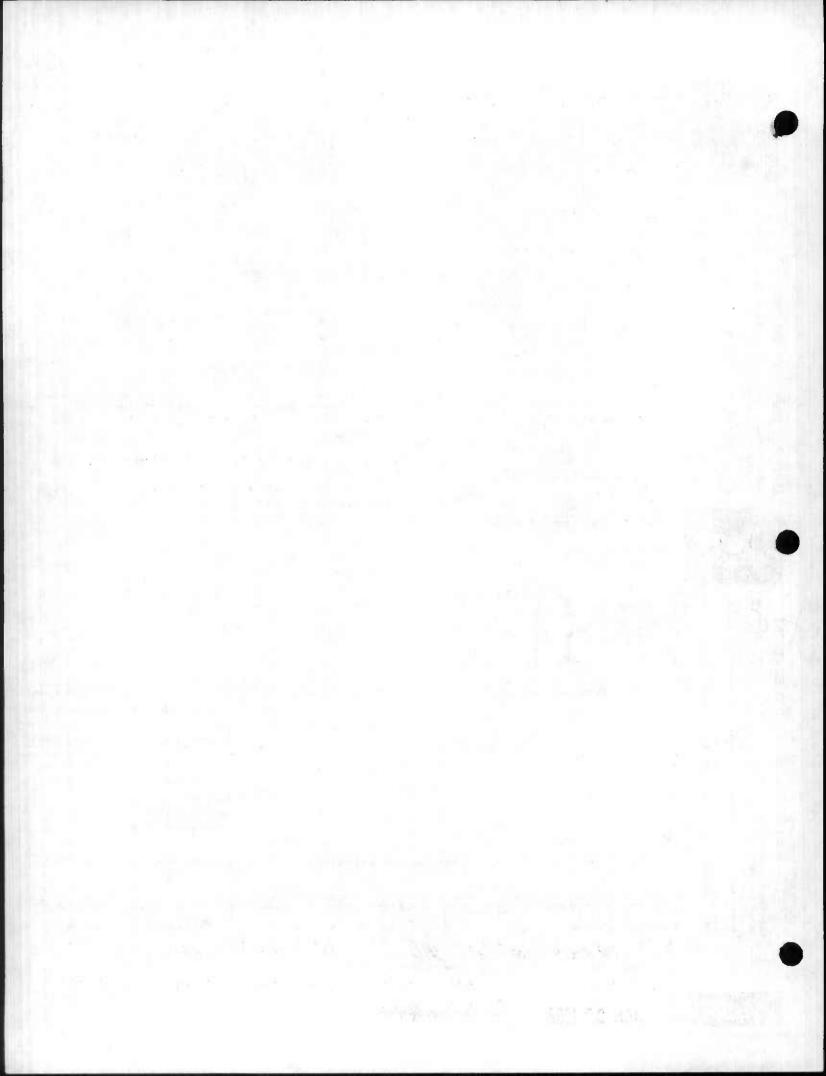
28b. Tima of

28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify)

Se America

State of Maryland / Department of Health and Mental Hygiene 98 0 1 7 6 3

					Cer	tificate of	Death		100	Reg. No.	, 0	1700	
Physic /Med		1. Decedent's Name (First, Middle, I	DLUGOK	ESKI					2. Dete of Dec Month JAN.	Dey	Yeer 98	3. Time of Death 5:15 pm	
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		7 South Stu	art Stre	et				ssex	<		Balt	imore	
Funeral Director		217-03-4924	Sex 1 M 2 □ F	Age (In yrs. lest bi 78	irthday) Yrs.	Months Dey		24 Hrs. Min.	8. Date of Birt (Month, Da Aug. 1,	y, Yeer)	Coun	lace (State or Foreign try) ryland	
Maryland f show	or	Usual Residence of Decadent 10a. State 10b. County Md. Balt	more	10c. City, Tow	vn or Loc	cation Esse	×		V 9		10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
or 28s	Director	10e. Street end Number	611			10f. Zip Code	01001			-	n of Whet Country?		
ath v	rai	7 South Stuart				-	21221			USA			
Z 1 Z 1 3-UUZU d within 72 hours after death with the Manyland piena. r than "naturel", or Items 23e or 28e-f show The Madical Example must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorcad	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? □ No		Vas Decedent of Yes, specify Cu ☐ Yes 2X No			ecity Yes or No- Rican, etc.)	Specif	ck, White, e		
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2 1 2 1 5 - UU 2 1 within 72 hours piena. r than "natural", The Modical Exa	Completed	Elementary/Secondary (0-12)	College (1-4o			no not use retir				Stee	ton C	an	
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Should be and Mental a marked o	2	unknown		140	unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)								
alth ar 27 la er trau		19a. Informent's Name/Relationship Robert Dlugokesk				Foot Hi			Belair 1			Code)	
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permit. Pages Department of Important: If It, any injury or o		21. Signature of Funeral Service Lio	onsee	11		Name end Add			Home of	Fecay			
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Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	e. Co	NG-637	Liv	e H	eart	- +	ailuv	e	 	Intervel Between Onset end Deeth	
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Attending P ar death.	Certification:	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 6 Could not			Time of njury	28c. Inju We M 1	ıry at ork?]Yes 2 □		28d. Describe h	ow Injury occur	red		
after d Direct d in by	ertifi	3 ☐ Suicide 6 ☐ Could not determine	286. Pleca of Ir	njury - At home, fa etc. <i>(Specify)</i>	ırm, stre	et, factory, offica		1	28f. Location (S City or Tow	treet end Numb n, State)	er or Rural	Route Number,	
To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the besi miner: On the besis and manner s	of examinetion en	downve	occurred et the t estigation, in my	ime, date en opinion, dee	d plece, e	and due to the co	ause(s) end me lete end plece,	enner as ste	eted. the cause(s)	
To th To th comp	Me	29b. Signature and title of certifier		1	/	29c. Licen				29d. Dete signe	d (Month, E	Dey, Year)	
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V		Man	The state of	ac un	0	1	017	80.		1-26	7	3	
8		30. Name and address of person who										21204	



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Tima of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last, 24, 1998 4:24 A.M. Isabelle DEVLIN January 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva straat and numbar) Franklin Square Hospital Center Rosedale Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) May 29, 1904 Birthplaca (Stata or Foreign Country) MAryland 5. Social Security Number 7. Aga (In yrs. last birthday) Days Hours Min 10 M 20 F Yrs. 220-05 1383 93 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore Rosedale 1 ☐ Yas 2 🗓 No 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 9726 Philadelphia Road 21237 USA Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forcas? 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Married 2 Marriad 1 ☐ Yas 2☐No Specify: White 3 Nidowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker own home 8th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Carrie Troyer Emmanuel Green 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 9726 Philadelphia Road Baltimore Md. 21237 Amy Devlin / daughter 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Gardens of Faith Cemetery 1/26/98 Rossville Md. 21. Signature of Funeral Sarvice Licensaa 22. Nama and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Entar tha disaasa, or so shock, or heart tailure. List on Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in death) 5 days Pneumonia Dua to (or as a consaquance of): Aspiration 5 days Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury Dua to (or as a consaquence of): that initiated avants rasulting In daath) Last Dua to (or as a consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Alzheimer's Disease 24b. Ware autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performad? Congestive Heart Failure 1 ☐ Yes 2 ☐ No Atrial Fibrillation 25. Was casa retarrad to medical axaminer? 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Direct

Funeral

P

Completed

r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at

filed within 72 hours after death Hyglene.

permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hyglen Important: if item 27 is marked other that any injury or other traumatic event, the page.

altimore, Maryland 21215-0020

the Maryland

2 ě ĥ Deen page 2 certificate has 84

27. Manner of Death 1 Natural
2 Accident

3 ☐ Suicida

29a, Cartifia (Check only

4 Homicide

31. Data filed (Month, Day, Yaar)

Pa Physician: funeral After Attending after death B ò Hospital within 24 hours

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be To Certification:

Examine

edical

State Registrar 29b. Signatura and titla of certitian

5 Panding invastigation

6 Could not be

JAN 27 1998

MO

28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

29c. Licansa number 150228

1 ∏Yas 2 □ No

28c. Injury at Work?

To the best of my knowledge, death occurred at tha time, data and place, and dua to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 98

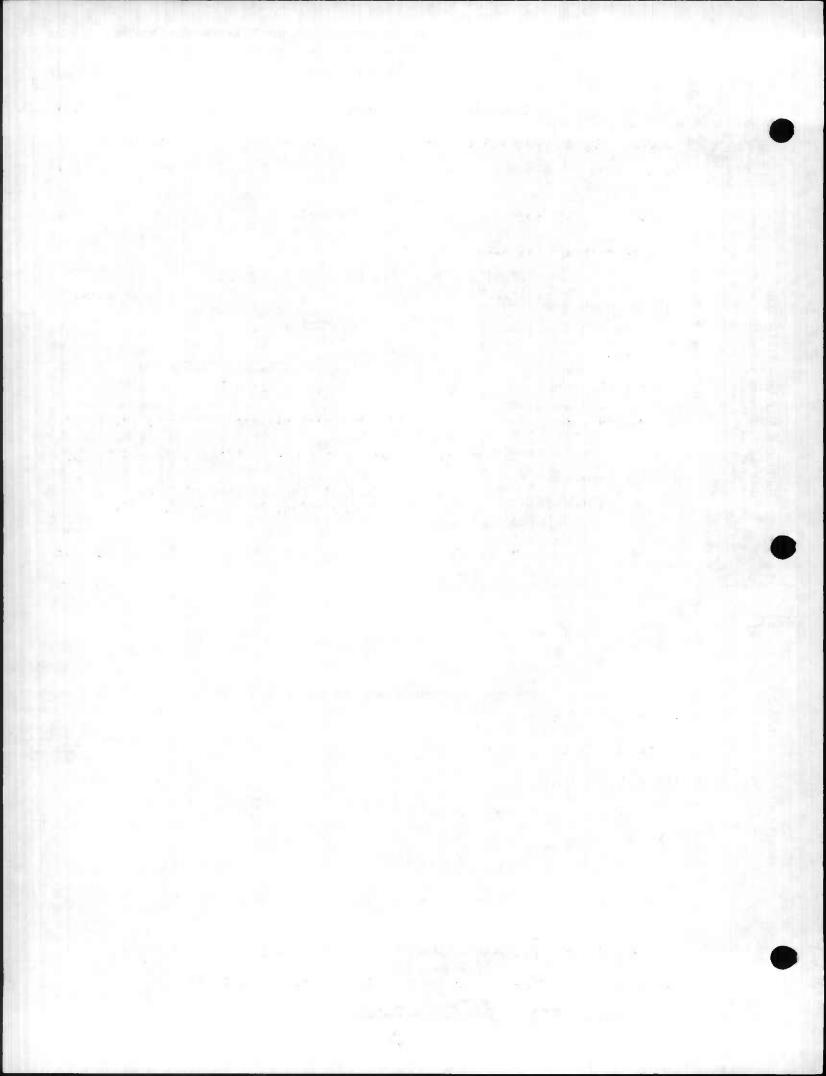
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print)

Dr. Erik Eways 9000 Franklin Square Drive Baltimore, MD 21237

32. Registrar's Signatura is Davidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth JAN) **Physician** AGNES Elchent 1015PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Howard County Howard County General Hospital Columbia If Under 1 Year Months Deys 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year, March 6, 1906 9. Birthplece (State or Foreign 10 M 200 Hours 217-09-2557 91 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Howard County Columbia Director 1 ☐ Yes 2 No 10f. Zip Code 21044 10g. Citizen of Whet Country? 10e. Street end Number 6336 Cedar Lane Funeral 11 Marital Statue Wes Decedent Ever in U.S. Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: py Specify: white 30XWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) garmet worker men's clothing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Agatha Milunas Vincent Levonas 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) Ms. Jaimie McVey/granddaughter P.O. Box 750626, Petaluma, California 94975 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20a Method of Disposition 20c. Location - City or Town, Stete Meadowridge Memorial Park 1-31-98 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Slack Funeral Home, P.A. 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. That only one cause on each line. Approximate Intervel Between Onset end Death mediete Cause (Final RENA diseese or condition resulting in death) Physician/Medical Examiner CAMDIOMYO Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of) CORONARY Due to (or es consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown DIVEN MONIA Be Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? VASULAN ACCIDENT 1 ☐ Yes 2 No 1 🗆 Yes No No 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 \subseteq Nursing Home 5 \subseteq Residenca 8 \subseteq Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Aaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide

P.O. Box 68760, Records, **Funeral**

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If Itam 27 is marked other that any injury or other traumatic event

Physician /Medical

Examiner

the Maryland

filed within 72 hours after

3altimore, Maryland 21215-0020

signed by the page certificate Division of Vital Hospital or Attending Physician: director, Certification: To funeral After death. d in by the 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) efter within 24 hours at To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

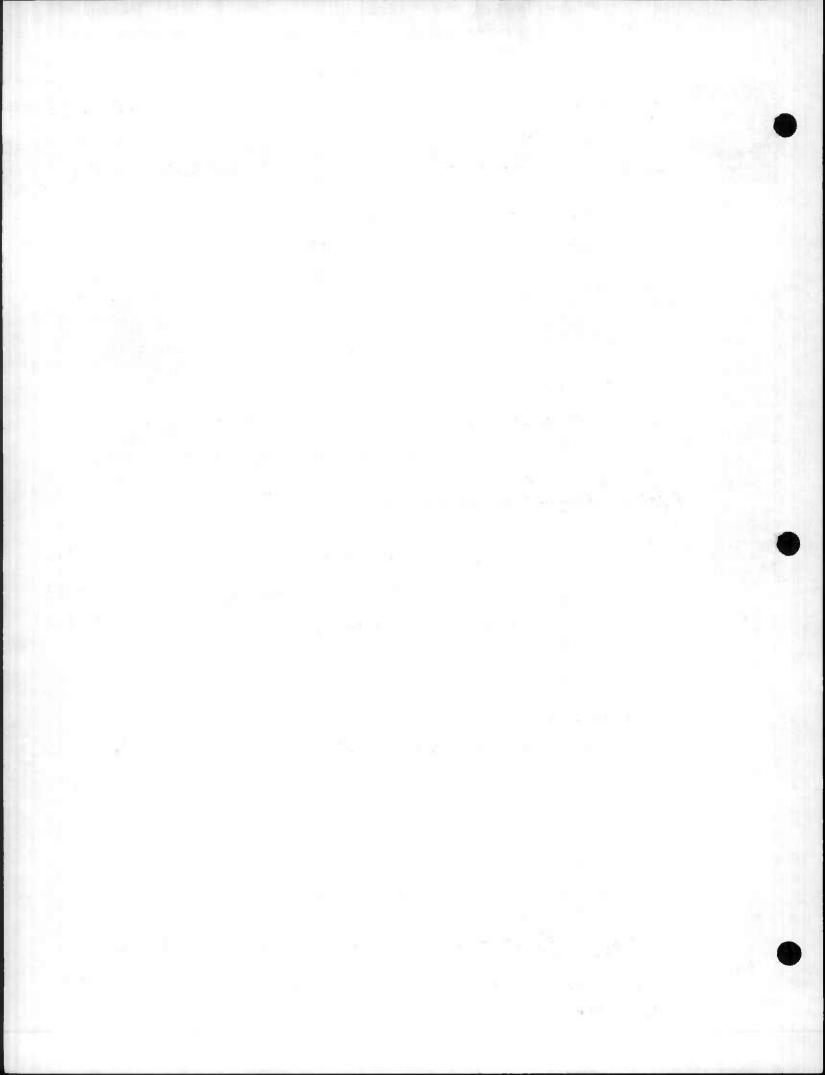
Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only one) To the 1 29b. Signature and the di certifier 29d. Date signed (Month, Dey, Yeer) 29c, License number

State Registrar MAUNICE

31. Date filed (Month, Day, Year)

1030 & B BAUTIMONE NATIONAL PIKE Ellicon GryMD CUFFEE MO 32. Registrar's Signature

completed cause of deeth (Item 23e) (Type, Print)

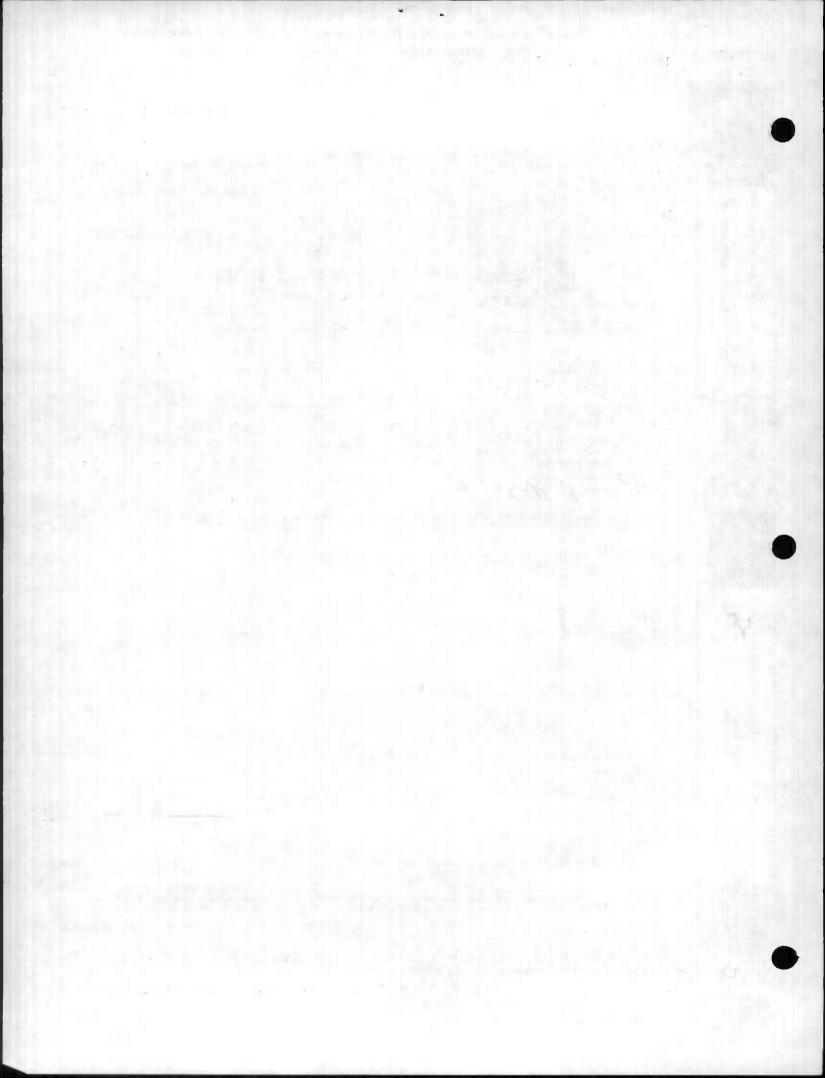


DHMH 16 Rev 6/95

State

Registrar

JAN 27 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Vivian Elizabeth Edson 4:25 Pin 25, 1998 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street end number) 4c. County of Deeth Union Memorial Hospital Baltimore If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Date of Birth (Month, Dey, Year) July 8, 1924 9. Birthplece (Stete or Foreign Days 1 M 2 F Months Hours 216-18-4993 73 Yrs. Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 4224 Falls Road 21211 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Spacify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, atc.) 11 Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorcad 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secratary Blue Cross/Blue Sheild 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Surnama) Calvin McClain Esther Gibson 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph E. Edson (Husband) 4224 Falls Road, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem 1/29/98 Owings Mills, Md. 21. Signeture of Funeral Servica Licansee 22. Neme end Address of Fecility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211 23a. Pert1. Enter the issues, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final acute mys candial 10 days diseese or condition resulting in death) respiratory Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated avents resulting in deeth) Lest estin Due to (or as a consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28e-f show

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items 23e

"netural", or

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permit. Pages 1 and 2 should be file Department of Heelth and Mantel Hy Important: if I lem 27 Is marked other any injury or other traumatic event once.

filed within 7 Hygiena.

72 hours aftar

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Records,

Division of Vital

the Medical Examiner must be notified

Director

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Completed

Be

Examiner

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Naturel 2 Accident

3 ☐ Suicida

29a. Certifiar

4 Homicide

(Check only one)

Union

31. Date filed (Month, Day, Year) JAN 27

Physician/Medical 2 for use an ed by the signed I þ Completed certificata director, Be Certification: To

funeral After or Attending s efter dec. • Funeral Di Hospital To the Hosp within 24 hor To the Fune completely fi

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Medical

State Registrar

Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated. 29b. Signature end title of cartifian

Howard

1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

29c. Licansa number AT 2438946

1 Yes 2 No

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

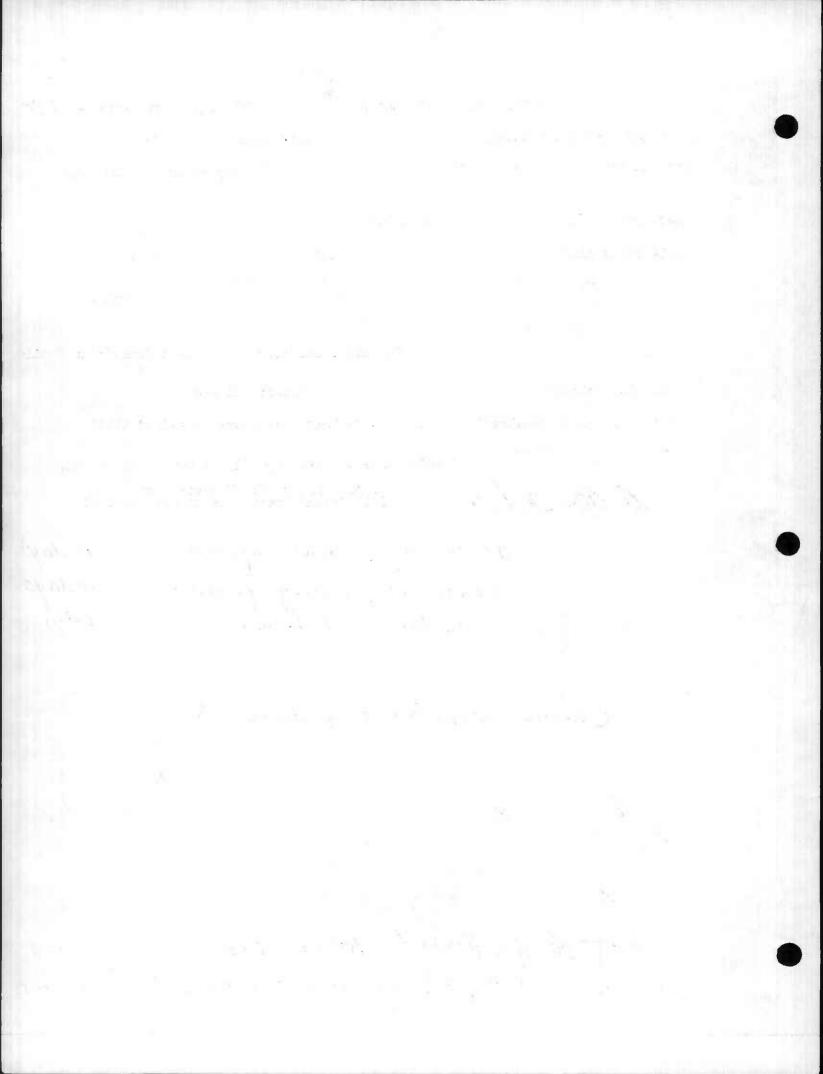
28d. Describe how injury occurred

29d. Date signed (Month, Dey, Yeer)

281. Location (Street end Number or Rural Route Number, City or Town, State)

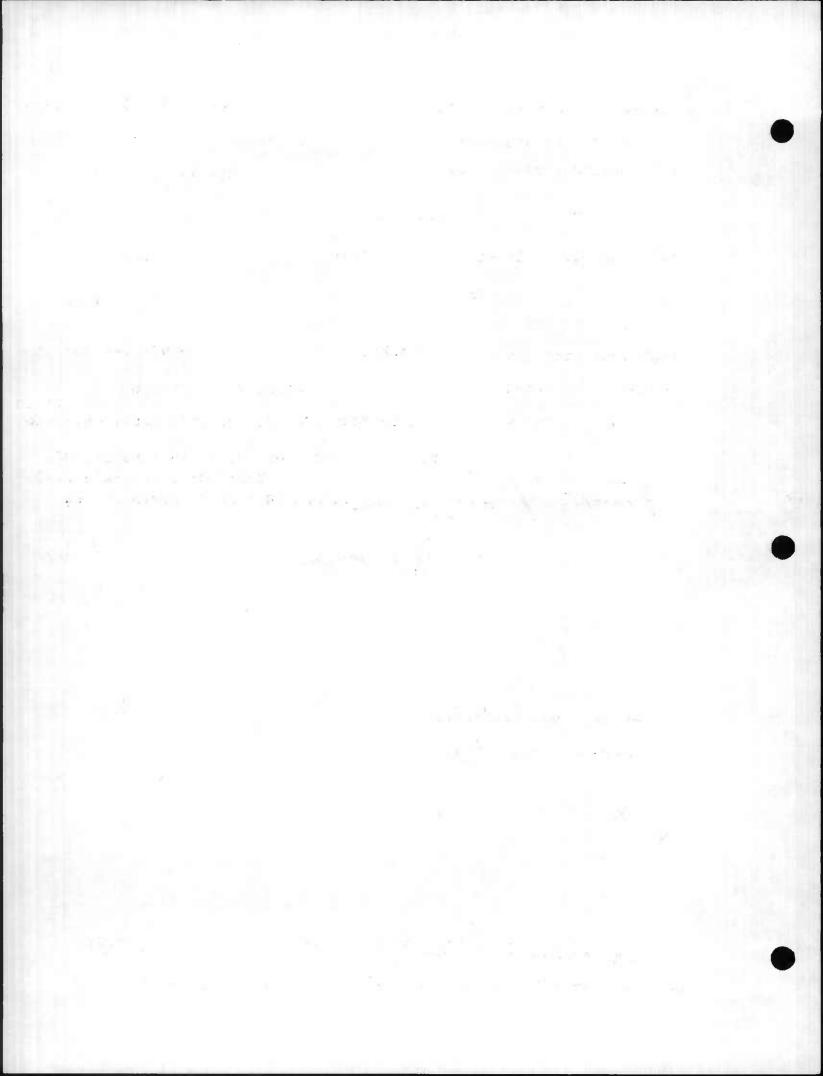
30. Neme end áddress ed cause of deeth (Item 23e) (Type, Print)

2201 University Parkwey, Baltimore, 2148 Hospital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month Jan. **Physician** 6:54pm James Fouch Martin /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straat and number) 4c. County of Death Examiner Johns Hopkins Hospital Baltimore NA 5. Social Security Number 6. Sax If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) **Funeral** Min. 1 1 2 □ F Months Days Hours 49 220-50-2103 Yrs. Director 03-07-48 MD Usual Residence of Decedent with the Merylend 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 7 is marked other than "nature!", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Baltimore 1 Nas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 East 20th Street 21218 USA permit. Pages 1 and 2 should be filed within 72 hours efter death Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23 any Injury or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yas, GiveX X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Spacify: 1 Yes PANO þ 3X Widowad 4 □ Divorced Black Completed Decedent's Usual Occupation
 (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) Elementary/Secondary (0-12) College (1-4or 5+) Packer Mayflower Van Line High Sch. Grad 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) James W. Fouch Dorothy Monroe 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21218 19e. Informent's Neme/Reletionship (Type, Pnint) Doretha Dudley 1105 East 20th Street Baltimore, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XDBurial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem. Pk. Cem. 01-27-98 Arbutus, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. of enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) viviedicai Conncer consequence am Examiner Due to (or as a Examiner physician and the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): esn 23b. Did tobacco use contribute to the ceuse of death? ed by the e Part II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t à 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? Completed completion of causa of death? certificate has 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 this funerai 28a. Date of Injury (Month, Day Yaar) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of Certification: 5 Pending investigation or Attending Naturel efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital
 24 hours
 Funerel Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 419 W. Redwood St. Sunte 360 Baltimore MD 2120/ Gray WD 32. Registrar's Signature guidson-Randell Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item #26 per Phy G756 2/3/98 EW 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** e.5/ax LMU21V /Medical 4e. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth Examiner

Funeral Director

Directo

Funeral

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the Maryland r than "natural", or frems 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours eftar death with Hygiana. marked other than permit. Pages 1 end 2 should be file Deportment of Health end Mental Hy Important: If frem 27 ie marked other any injury or other traumatic event sonce.

altimore, Maryland 21215-0020

Physician /Medical Examiner

> end -transit certificate director. After this

Exam The law requires that the daath certificate be exate hes been signed by the attending physician page 2 should be datached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical þ Completed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice Be 2 Certification: er death. filled in by 24 hours a edical To the Hosp within 24 hor To the Fune complately fi

3. Time of Deeth 4c. County of Deeth Parkton 500 Dairy Road Baltimore Co. 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5,1926 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours 1 € M 2 □ F **Yrs** 71 160-20-5556 Pennsylvania Usuel Residence of Decadent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yas 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 United States 8205 Bear Creek Drive 12. Was Decedent Ever in U,S. Armad Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yas 2 No If Yes, Give Yaer or Dates: 1 Navar Married 2 Married 1 ☐ Yes 213 No Specify: White WWII Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automobile Industry Final Repairman 5 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) Arvilla Hess Bert Felix 19e. Informent's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 7834 C. E. Collingham Drive Dundalk, MD Mr. Lester R. Felix, Jr 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete ₩ Burial 2 Cremetion 3 Removal from State Gardens of Faith Cem. 1/19/1998 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funarel Service License 22. Neme and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23e. Port1. Enter the disease, or complications thet caused the deeth. Do not antar the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each lin Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 24a. Was en autopsy

ther significant conditions contri	buting to death but not ra	sulting in the underlying	g cause given in Pert I
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Mercon	de la		
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3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of daath? 1 Yas 2 No 1 Vas 2FINO

25. Wes case referred to medical							26.	Piece of De	ath (Check only one)		500 0 1	
axeminar?	lo	Hospitel: 1 🗆 In	patient 2	ER/Outpatient	3□	DOA	Other:	□ Nursing	Home 52 Residence	6 XXOther (S)	pecify) n parked Va	
27. Menner of Death 1. Netural 2 Accident	5 Pending investigation	1	Injury , Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 Yes	2 🗆 No	28d. Describe how Inj	28d. Describe how Injury occurred		
3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined							fice 28f. Location (Street and Number or Rural Ro				

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

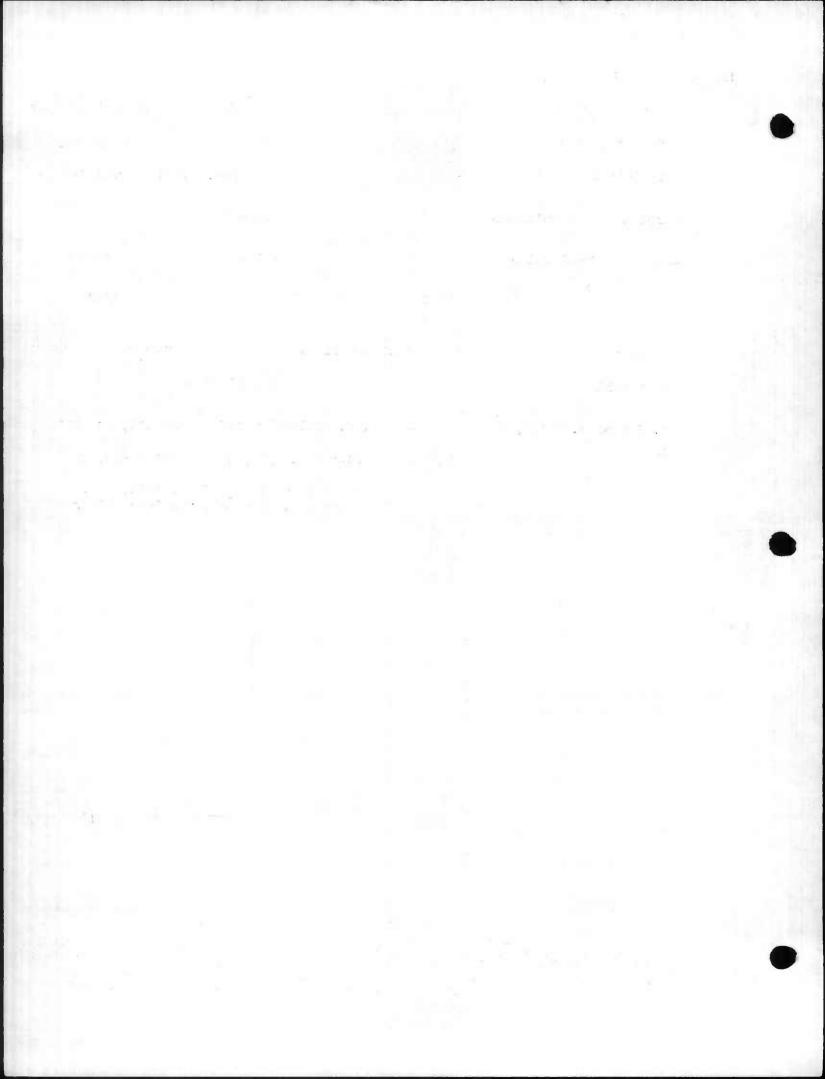
**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifian

29b. Signeture end title of certifier 290 License number 29d, Dete signed (Month, Day, Year)

ne and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 0264 ve//6)

31. Deta filed (Month, Day, Year) State Registrar

32. Registrar's Signeture wa Daydoon Handell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 23,1998 Month January 1:40 am Clarice J. Wheeler Foster 4a. Facility Name (If not institution, giva street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Apt.1105 1100 Bolton Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) 9. Birthplace (Stata or Foraign Days 1 M 2 F Yrs 217-24-2416 67 April 30,1930 Md Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Bolton Street Apt. 1105 U.S.A. 21201 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes XXNo If Yes, Give Year or Dates: 1 Never Married X Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)

the Maryland 28a-f show the Medical Examiner must be notified at 6 items 23e filed within 72 hours after Baltimore, Maryland 21215-0020 "neturaf", or nd Mental Hygiene. Pages 1 and 2 should be frent of Health and Mental Int: If Item 27 is marked of other č permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a State

Director

Funeral

Funeral

Director

Physician /Medical Examiner

> Physician/Medical Examiner þ Be Completed

page 2 Hospital or Attanding Physician: 24 hours after death.
Funerel Director: After this certifica stely filled in by the funeral director. in by 24 hours a To the Hosp within 24 hor To the Fune completely fi

P.O. Box 68760

Records,

Division of Vital

by Completed 15. Decedent's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) 12th school nurse Balto.City Pub.Schoo 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) William Henry Mason Sr. Hilda Kenard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) John A.Foster Sr.-Husband 1101 Bolton St.Balto.Md.21201 Apt.1105 20b. Plece of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 1/28/98 Balto.Md. 21. Signature of Funeral Septile Line 22. Name and Address of Facility Caple Funeral Service 5502 Winner Ave.Balto.Md.21215 23a Part. Enter the disease, or omplications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Anoroximete Onset and Death Immediate Cause (Final Sudden cardiac death disease or condition resulting in deeth) Due to (or as a consequence of) Hyperlipidemia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as e consequence of): Discoid lupus erythematosus Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Medicai 29a, Certifier 🖎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MBoyne, MD

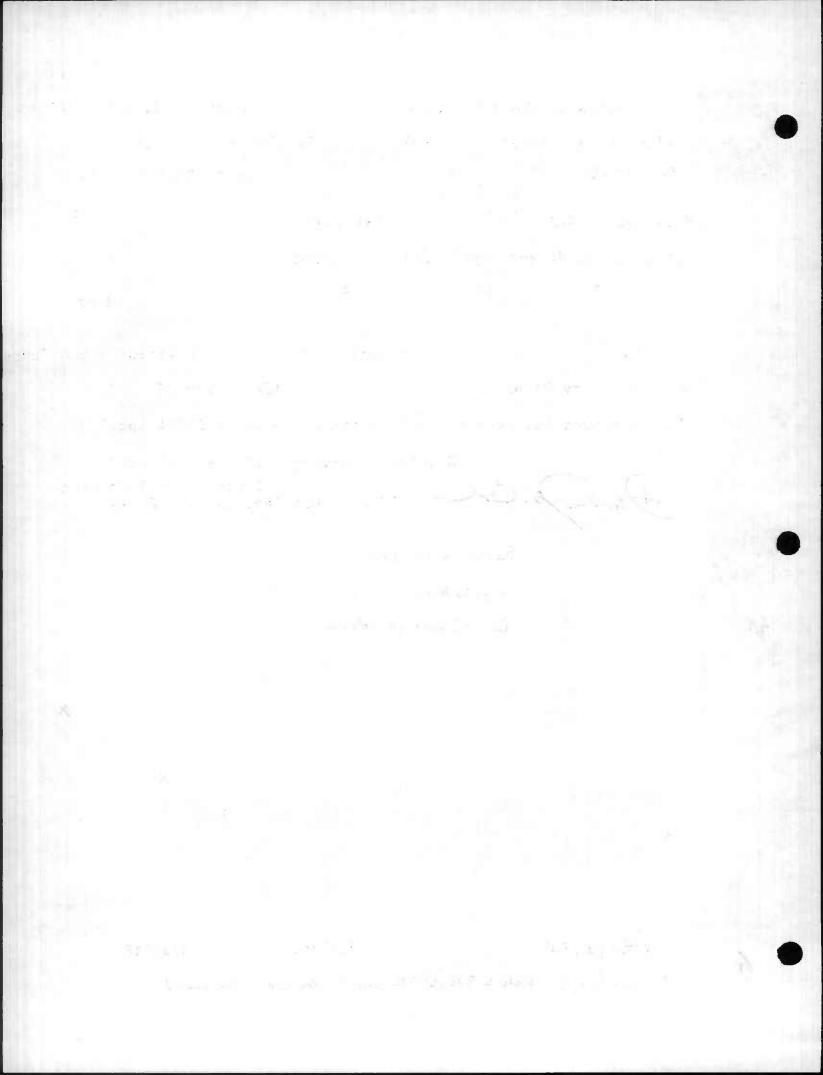
Blalock 903, LOO N. Wolfe St, Baltimore MO 21287

32. Registra signatur

State Registrar 30. Neme end address of person who completed cause of death (ttem 23a) (Type, Print)

Michael Boyne,

31. Date filed (Month, Day, Year) JAN 27



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes

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Funeral Director	10e. Street and Number 1 Eastern Ave. 10f. Zip Code 21221 10g. Citizen of What Country? USA														
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1 Decedent's Name (First, Middle, Last) Month Day Vaer **Physician** 26, 1998 6:20 **FEEHLEY** January am Doris Elaine /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Baltimore Franklin Square Hospital Center Rosedale If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) June 10, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 1□M 2☑F 73 Yrs. 216-16-1640 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10b. County 1 ☐ Yes 2√ No Baltimore Essex Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ä ir than "natural", or items 23s or 21221 USA 8620 Kelso Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s any injury or other treumente event, the Medical Examinet man once. Funerai 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Poly - Seal Machine Operator 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be MAry Schmidt Roland Riser 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2304 Taylor Ave. BAltimore Md. 21234 William J. Feehley/son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/98 Baltimore MD. OakLawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part 7. Enter the disease, or compilinations that ceused the death of not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only our cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Ventricular Fibrillation 15 minutes Examiner Due to (or as a consequence of): Examine 2 months b. Congestive Heart Failure Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or InJury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai . Hypertension Due to (or as a consequence of): 2 8 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 6 8 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. È 1 Yes 2 No 3 Probably 4 A Unknown Diabetes Mellitus þ 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy Completed Hypothyroidism page 2 Ž 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 80 Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ■ Inpatient 2 ER/Outpatient 3 DOA Pils 28a. Date of Injury (Month, Day Year) uneral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? Certification: Attar Attending 1 Natural 5 Pending 1 Yes 2 No investigation death. 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 斯 6 n 24 hours Ne Funeral Dir ğ edicai 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the Within 2 To the Warerz

State

n

JAN 27 1998 Registrar

29b. Signature and title of certifier and

31. Date filed (Month, Day, Year)

9000 Franklin Square Dr. Baltimore Md. 21237 Savitha Shivananda MD, 32. Registrar Sanature

MD

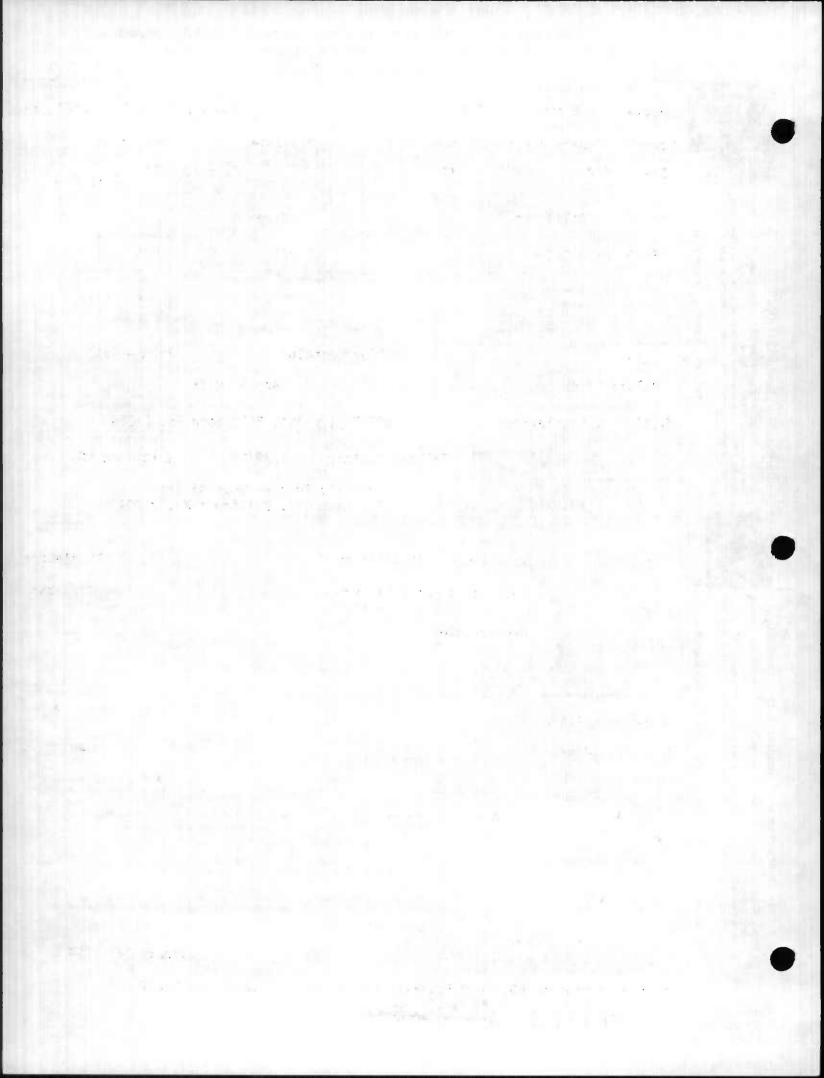
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

29c. License number

D52379

29d. Date signed (Month, Day, Year)

January 26, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** 8 am January GURALNICK ELAINE /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3031 FALLSTAFF ROAD #202 BALTIMORE N/A If Under 24 Hrs. 8. Data of Birth Hours Min. JAN 22, 1926 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) **Funeral** 10 M 72 219-12-6571 Yrs. Director Usuel Rasidance of Decedant tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, in Mastesi Examinet must be notified a once. Yas 2 No Director MD N/A BALTIMORE 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of Whet Country? Guralnick 3031 FALLSTAFF ROAD 21209 U.S.A. 13. Was Dacedant of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indien, Black, Whita, atc. 12. Was Decedant Evar In U,S Armed Forcas? 1 Yas 2 No If Yas, Giva XX Yaar or Datas: 1 Navar Married 2 Marriad 1 ☐ Yes 2 No Specify: P Specify: XX Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) VOLUNTEER JEWISH ORGANIZATIONS 17. Fether's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Elaine MEYER WOLPERT JENNIE ROBINSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BONNIE GURALNICK / DAUGHTER 6923 BLANCHE ROAD BALTIMORE, MD 21215 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Burlal 2 Cremetion 3 Ramoval from Stata BETH TFILOH CONGREGATION 1/25/98 BALTIMORE, MD 4 Donation 5 Dothar (Specify) 21. Signatura of Funerel Sarvice Licensas 22. Nama and Addrass of Facility Sol Levinson & Bros., Inc. Shock, o haart failura. List only one cause on each ha. **Physician** Immediate Cause (Finel disaasa or condition rasulting in death) /Medical Myocardial infarction hours Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initieted evants rasulting in death) Lest Dua to (or as a consequence of): Box 68760. Due to (or as e consequence of):

usa has

Division of Vital Records, P.O.

funeral director, this daath. i or Attandi after death Director: A the

Physician/Medical þ Completed 2 Certification: 27. Menner of Death

Medical

Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. diubete s

25. Was casa rafarred to madical axaminar? 1 Yes 2 No

4 Homicida 29a, Certifian (Check only one)

29b. Signature end title of partition

31. Date fliad (Month, Day, Year)

JAN 27 1998

1. Netural

2 Accident

3 Sulcida

28a. Data of Injury (Month, Day Year) 5 Pending Investigation 6 Could not be datermined

28a. Placa of Injury - At home, ferm, straat, fectory, office building, atc. (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

28c. Injury et Work? 28b. Tima of 1 Yes 2 No

Certifying Physicfan: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to the causa(s) and menner stated. 29c. Licanse number

mo 30. Nama and addrass of person who complated causa of daeth (Itam 23a) (Type, Print)

D34849

January 23, 1998

1645 Liberty Road Eldersburg MD William Tan, MD

> 32. Registrar's Signatura Inia Davidson-Randolle

Registrar

DHMH 16 Rev 6/95

To the Hoppital c within 24 hours at To the Fundal D completely filled i

24b. Wara autopsy findings avellable prior to completion of causa of daath?

1 ☐ Yas 2 ☐ No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

23b. Did tobacco use contributs to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown

29d. Data signed (Month, Day, Year)

24e. Wes en eutopsy performed?

26. Placa of Daath (Check only ona)

1 Yas 2 No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death Reg. No.

				Cei	tificate c	of Death	F	leg. No.	U	1/14
Physi	ician	1. Decedent's Neme (First, Middle, La					2. Dete of Dee Month		Year	3. Time of Death
	dical	Milton	Greenbe	rg			Januar		1998	1-45 PM
Exam		4a. Fecility Name (If not institution, giv	e street end number)			4b. City, Town,	or Location of Deeth	4c. County	of Deeth	
		World War	tical cen	ter		Balt	simore	N/A	A	
Funera Directo			ex 7. Age (In yrs.	lest birthdey) Yrs.	If Under 1 Ye Months De		in. (Month, Dey	Year) 2,1935		lece (Stete or Foreigr try) YLAND
and w		Usuel Residenca of Decedent 10a. Stete 10b. County	10c, Ci	ty, Town or Lo	cation				10	0d. Inside City Limits
he Marylan 28a-f show off ed at	ector		/A		BALTIMO					tX Yes 2 No
ath with 1	Funeral Director	10e. Street end Number 6952 GLENHEIGHTS			10f. Zip Cod	215		0g. Citizen of US		try?
n 72 hours after death with the Maryland "neturel", or items 23s or 28s-f show ed sel Examiner mant be notified at	þ	11. Marital Status 1) Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:		Wes Decedent of Yes, specify C	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ca - America ck, White, e by: WH	
gas 1 and 2 should be filed within 72 ho it of Haalth and Mental Hygiena. If Item 27 is marked other than "natur or other traumatic event, The Medical	Completed	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16e. Deced	lent's Usual Oc	cupation ne during most of v	working	16b. Kind of B	usiness/Ind	lustry
withIn iena. then "	ig.	Elementery/Secondery (0-12)	College (1-4or 5+)	life. L	DO NOT use re	tired)	roiking			
e filed within al Hygiena. other then "	3		2		SUPERVI	T		SOCIA		URITY
d oth	Be	17. Father's Name (First, Middle, Last)					leme (First, Middle,		-	
should be nd Mental marked o	2			REENBER		BELI			RAMER	
2 sho		19a. Informent's Neme/Reletionship (Rural Route Number			
other tr		MARVA STOKES (PER				EIGHTS RD		ORE, MI		
Pegas ment of F ant: If ite ury or ot		20a. Method of Disposition 1 \[\frac{1}{2}\]Burial 2 \[\]\ Cremetion 3 \[\] 4 \[\]\ Donetion 5 \[\]\ Other (Specify)	Removal from Stete	cemetery, cren	sition (Neme of netory or other) TIKVAH	place)	1/25/98	20c. Location -	DALE,	
permit. Pega Department of Important: If any injury or	SUC.	21 Cignature of Funeral Service Licen	S00 P				BROS., INC		I.E. M	מוצות ת
certificate be executed xx and in the control of the control of the control of the central of th	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inflieled events resulting in deeth) Lest	b. Crohns Due to (c	or as e consequence or es e consequence	uenca of):					20 years
0 2 2	Physician/	Pert II. Other significent conditione or	d	sulting In the ur	nderfying cause	given In Pert I	23b. Did to	obacco uea co	entribute to	the cause of death?
requires that tha death been signed by the atter hould be detached for u	by Phys	Small Bo	0 0	truck			1□ Y			pably 4 Unknow
2 S S	Completed t	Respirato	ry Fail	une	•		24e. Wes e perfor		ava	ere eutopsy findings allable prior to mpletion of cause deeth?
The law ete has t page 2 s	lo.		The Villa Co.				1 🗆 Y	es 2 No	1 🗆	Yes 2□ No
ysician: The is cartificete director, pag	Be (25. Was case referred to medical				26. Plece of D	Death (Check only or	ne)		
5 5	10	exeminer?	Hospital: 1 Inpatient 2	ER/Outpetien	t 3 DOA	Other: 4 Nursing	g Home 5 ☐ Reside	ence 6 Oth	ner (Specify	1)
Attending Ph r death. ector: After th by the funeral	ation:	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury		njury et Work? Yes 2 No	28d. Describe h	ow injury occur	red	
or Attender	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, fectory, offi	се	28f. Location (S. City or Town	treet end Numb n, Stete)	ber or Rure	l Route Number,
he Mospital or Attending Print 24 hours after death. he Funeral Director: After the pletely filled in by the funera	edical	29a. Certifier Check only one) 2 Medical Exam	rsicien: To the best of my kno iner: On the basis of examina end menner steted.	owledge, death ation end/or inv	occurred at the restigation, in m	time, date and pla y opinion, death oc	ace, end due to the courred et the time, d	euse(s) end me ate end place,	enner es st end due to	eted. the cause(s)
To the Nuthin 2 To the Complete	Me	29b. Signature end title of certifier	chkar M.D			ense number	-	9d. Date signe		Dey, Yeer)
11 130		30. Neme end eddress of person who of Vijay Pethka	completed ceuse of deeth (Iter	n 23e) (Type, I		Balt	imore		1	2 .
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	eture						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** January 24, Louisa Margaret George 0330 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Deeth Examiner Genesis-Franklinwoods Baltimore County Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, June 15, 9. Birthplece (State or Foreign Country) Jersey City, N.J. 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2□ F 174-34-8835 55 Yrs. Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Baltimore County 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 1316 Washington Irving Lane USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiena. Important: If Itam 27 is merked other than any injury or other traumetic event. Elementery/Secondery (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frank Brown Lottie Unknown 0 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Philip W. George (Husband) 1316 Washington Irving Lane Baltimore, Maryland 21220 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. January 27,1998 Baltimore, Maryland 21. Signature of Funerel Service Licenses 22. Name end Address of Facility
Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 MOCI 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Onset end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the the burial ransi Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thef initiated events resulting in death) Lest Due to (or es e consequence of): Records, P.O. Box 68760. Due to (or es e consequence of): The law requires that the death certificate attanding 0 Part II. Other eignificant conditione contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobecco use contribute to the cause of death? ate has been signed by page 2 should be datac 1 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Be Completed 24a. Wes en eutopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ HO Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

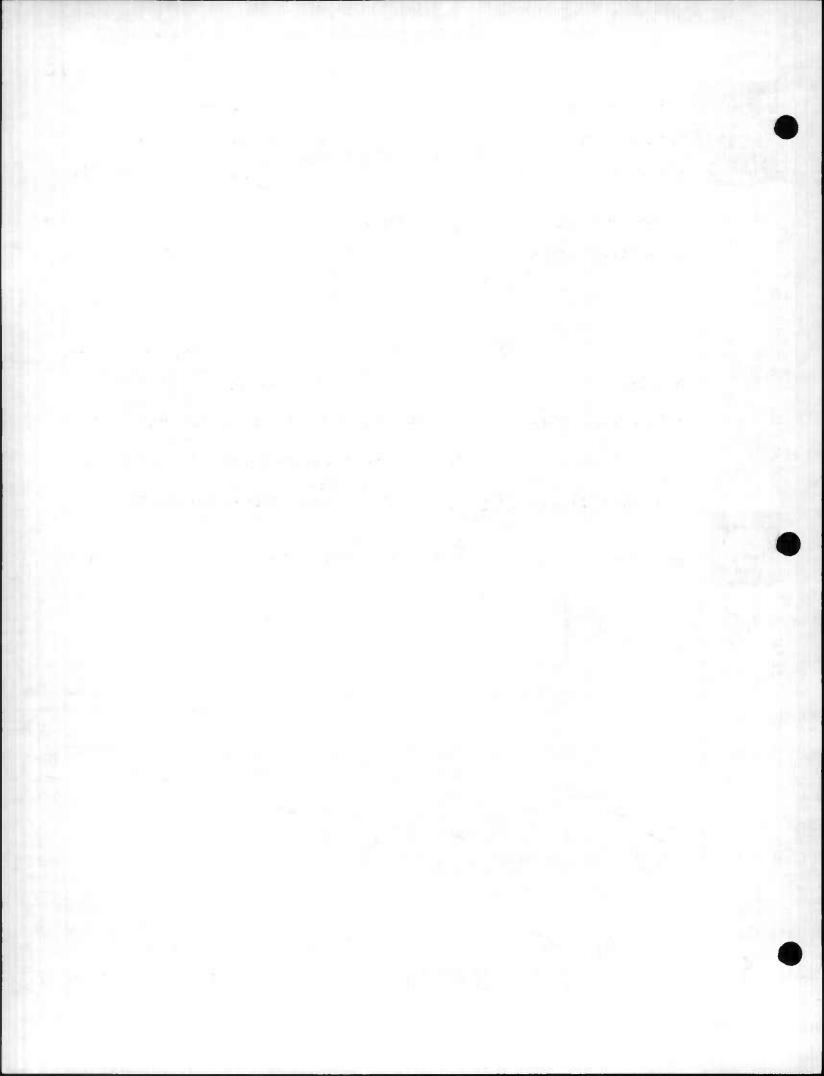
To the Funeral Director: After this certifica 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Medicai Certification: 1 Waturel 5 Pending 1 Yes 2 No 2 Accident investigation 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide 1 Certifying Phyelcfan: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Yeer)

THAN(

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) KUIB 68030 Registrer's Signeture was Davidson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death JANUARY **Physician** HENRY J. GROMEK 0100 /Medical 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** NURSING Home Home BALTIMORE CHURCH If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10M 20 F 70 161-20-0256 Yrs. December 16,977 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner near be notified at Director MD NIA BALTO, CIT 1 Tes 2 □ No 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death wi Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a. any injury or other traumatic event, the Medical Examiner mants any injury or other traumatic event, the Medical Examiner mants Bradford. ST. 71934 U.S.A 12. Was Decedent Ever in U,S. Armed Forcas?
1 ☐ Yes 21 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1□ Yas 2□No Specify: Baltimore, Maryland 21215-0020 by Specify: WHIE 3 ☐ Widowad 4 ☐ Divorcad Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Merchant marines NIA COOK 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) STECZKOWSKI PAULINE JOHN Gromek 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) YAVLA BOOZ BALT, MD 213 MAPIE AVE 20e. Method of Disposition
1 ☐ Bunial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Placa of Disposition (Neme of cemetery, cremetory or othar pleca) 20c. Location - City or Town, Stata 1-24-98 BALT, MD 4 ☐ Donetion 5 ☐ Other (Specify) Greenmont Cem. 21. Signetura of Funerel Sarvica Licensae 22. Name and Address of Fedility HARTLEY Miller Frugal Home Mill 7527 Harford RD BACT, MD 21234 23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Chronic Obstructive Pulmonay Disease /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Glass Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760 Dua to (or es e consequence of): Hospital or Attending Physician: The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Degenerative Arthrifis Completed by Dementia 24b. Were eutopsy findings evailabla prior to completion of causa of deeth? Serile 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) Certification: To 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? After 1 Naturel 5 Pending Investigation s efter death. 1 Yes 2 No 2 Accident in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 26f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of axaminetion end/or invastigation, in my opinion, death occurred et the time, dete end piace, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one)

29c. License numbar

40356

Ored Specialist

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
WENEUSA NAVARRA, NO 100 N. Brookway, Boetimore, Wangland

32. Register's Signature

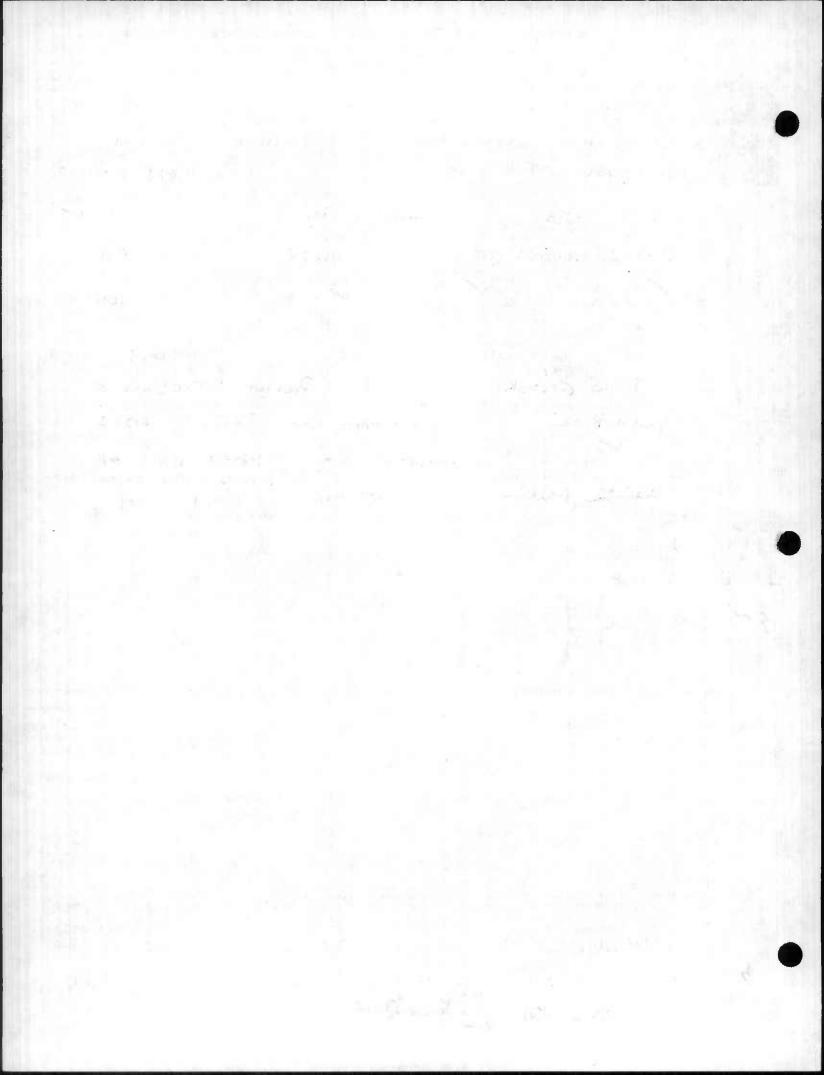
Fishe Davidson-Randall

29d. Data signed (Month, Dey, Year)

State Registrar 29b. Signature and title of certifier

31. Deta filed (Month, Dey, Year)

JAN 27 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item: 20b Per FH Film G-755 1-27-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** HARDY EDNA US:25A JAN /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN HOSPITAL BALTIMORE 1/13 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Sociel Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 2/5-285 958
Usual Residence of Decedent 10 M 204 Yrs. Director Marylows 6,1933 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show ther must be notified at 1 Fres 2 □ No Director Mary Sho 10e. Street end Number BALTIMOR 10f. Zip Coda 10g. Citizen of What Country? 5607 FURDUE USA 21239 Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yas, Give Year or Detes: 13. Was Dacedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, 11. Merital Status 7 is marked other than "natural", or item traumatic event, the Medical Exeminer Black, White, etc. 1 Never Merried Marriad 21215-0020 1 ☐ Yes 2 No Specify: Specify Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry HighLand HEALIN tai Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) NUISE Assistant FacilitiEs arode 17. Fathar's Nama (First, Middla, Last) Baltimore, Maryland permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other any liury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Margaret Mullen 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 659 19e, Informent's Name/Relationship (Type, Print), BALTIMOR, Marylono POHNNIE PURDUE AUG HUSBARD 5607 Dete 20c. Location · City or Town, State 20b. Pleca of Disposition (Neme of 20a. Method of Disposition Burial 2 Cremation 3 Removel from State BALTIMOR, HICK 4 □ Donation 5 □ Other (Specify) ress of Facility CHATMAN - HAM'S FUNAL Home 21. Signeture of Funeral Service Licensee 240 RCISTENSTIUN LOAD 23a. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and the such as the s Approximate Intervel Between Onset and Death **Physician** /Medicai Immadiata Causa (Final CANCER LUNG MONTHS disease or condition resulting in death) Examiner Examiner CANCER ESOPHA G EAL MONTHS Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or es e consaquence of): P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records, should be d à 24b. Were eutopsy findings eveilebla prior to completion of cause of deeth? Completed 24e. Wes en eutopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funerai 28a. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 1 Naturel 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter deat 6 Could not be 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medicai (Check only one)

31. Date filed (Month, Dey, Year) State Registrar

29b. Signature end title of certifier

ANDRZEJ JANECKI, JOHNS Registrar's Signature

30. Neme and eddress & person who completed cause of deeth (Item 23e) (Type, Print)

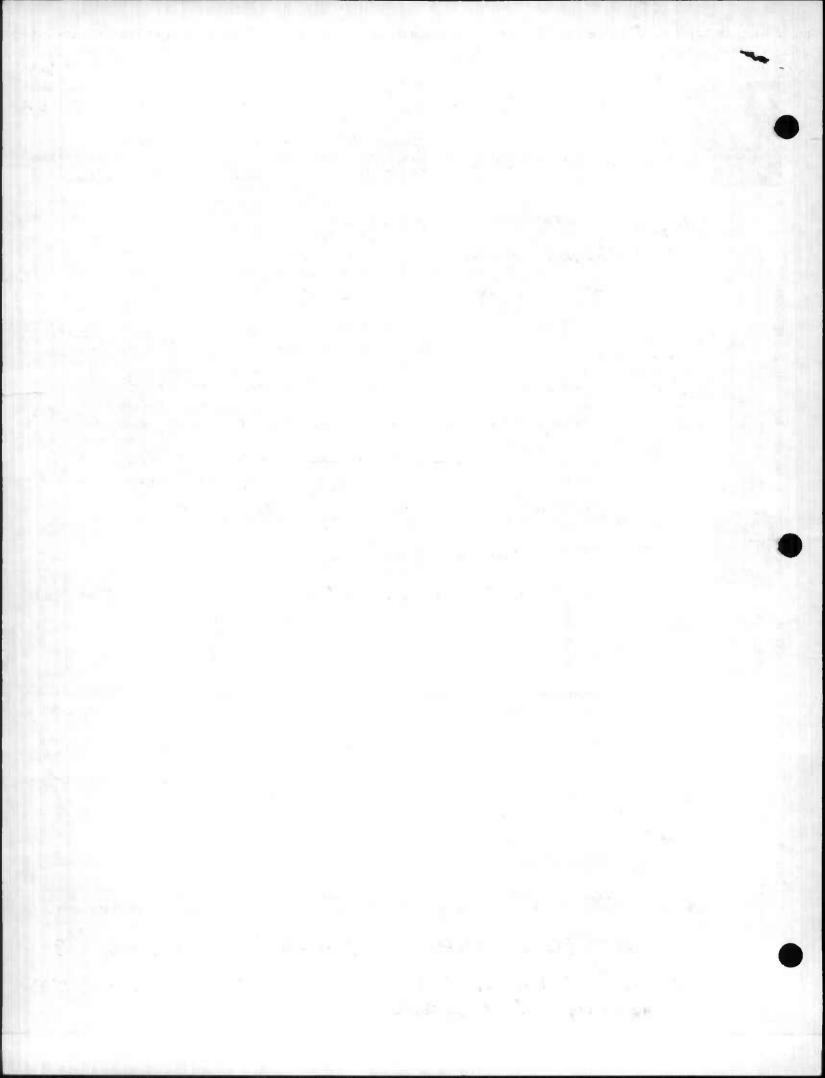
M.D

29c. License number

D47014

29d. Date signed (Month, Dey, Year)

HOPKINS HOSPITAL, BALTIMORE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Forrest L. Harvey 4:00 P.M. 1998 Januar 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 316 Panorama Way Baltimore Anne Arundel 5. Social Security Number If Under 1 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Days 10XM 2□ F 215 30 9370 Yrs. 63 July 9, 1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 316 Panorama Way 21225 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1952–1972 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorcad White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Technician Telephone Company 12th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) (not available) Sarah M. Harvey 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21225 Beverly M. Harvey / wife 316 Panorama Way 20b. Piece of Disposition (Neme of cametery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 Removel from State 1/28/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on eech line. Approximete Intervei Between Onset end Deeth tmmediate Ceuse (Final Von-small Cell Lung Cancer diseese or condition resulting in death) Due to (or es e consequence of) Due to (or es e consequence of): Due to (or es e consequence of) ferentiated, Non-small Cell Lung (ancer 005 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Wes en autopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

signed by the aid

peed pege 2

certificate

Director: /

Be

2

Certification:

Medicai

29b. Signature and little of certifier

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

ŏ items 23a Director

Funeral

þ

Completed

2

traumatic event, the Medical Examiner must be notified at

marked other than "natural", or

Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: if Itam 27 is marked oths any injury or other traumatic events

the Manyland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

Physician/Medical Examiner Completed by

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifies completely filled in by the funeral director, it 101)

State Registrar

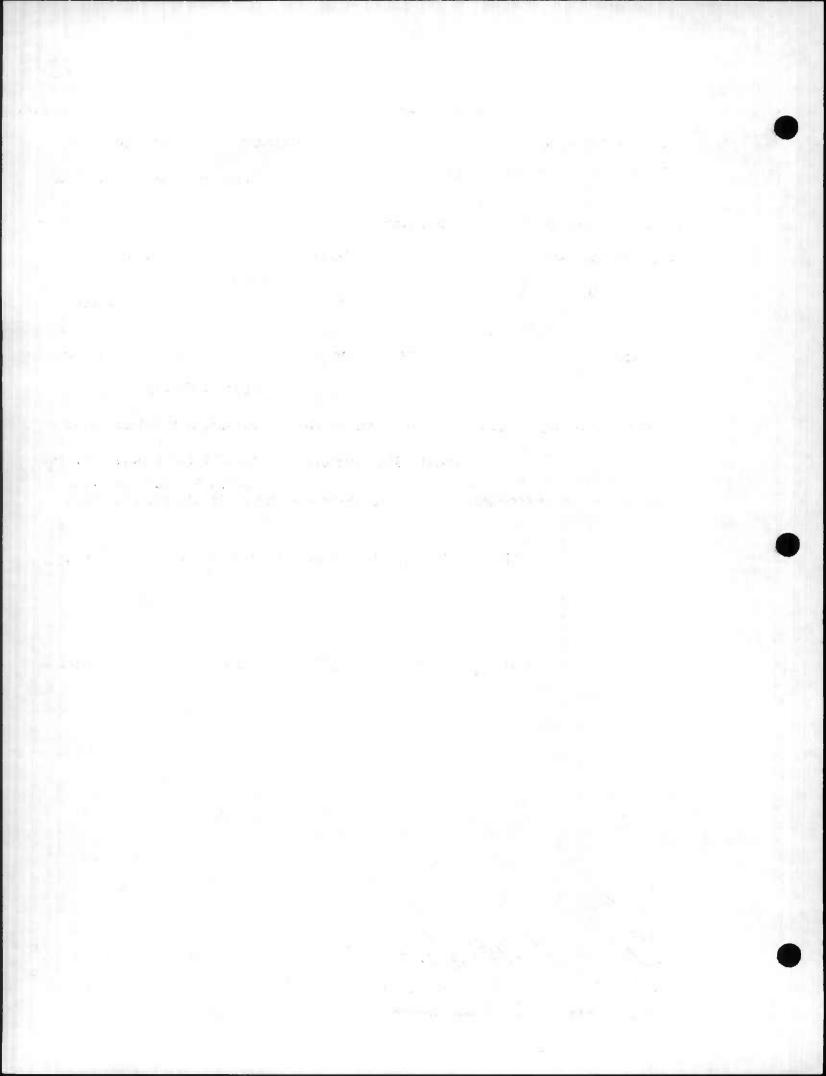
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 AResidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 5 Pending Investigation 1 Naturel 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end pieca, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end piaca, end due to the ceuse(s) end menner steted. 29a. Certifier

29c. License number

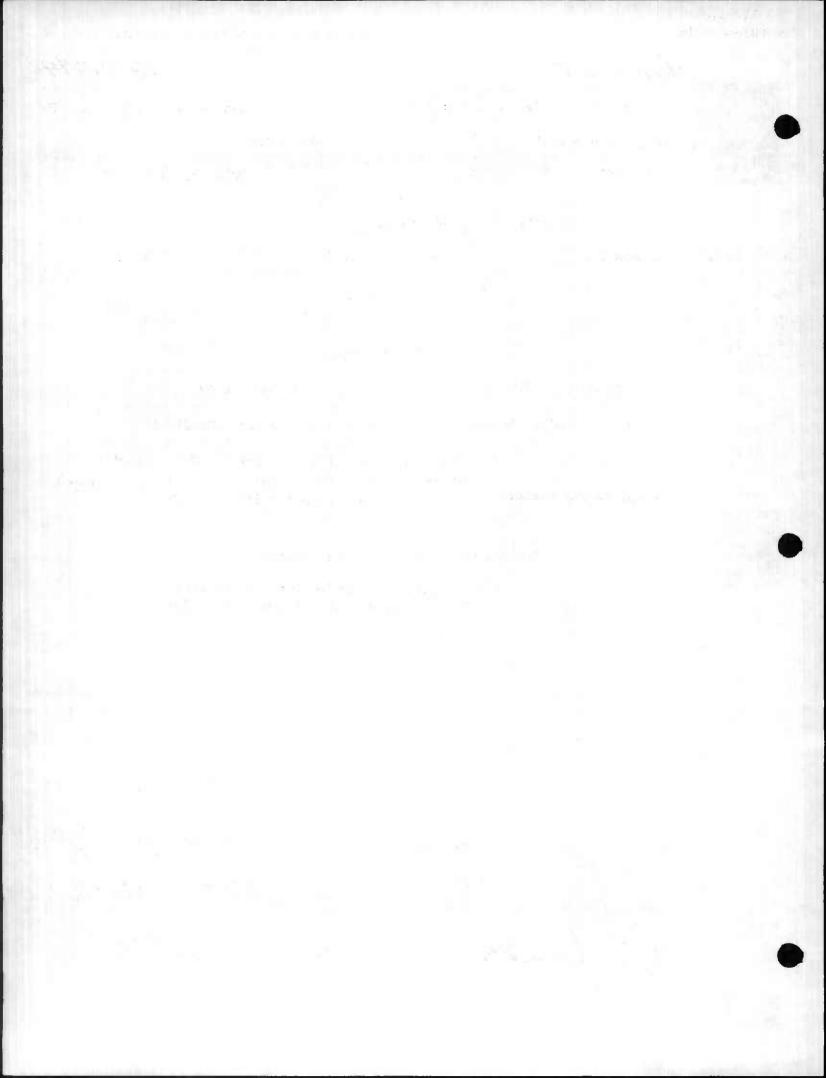
1,0-0,0 3001 Hanover 31. Dete filed (Month, Day, Year) JAN 27 1998

(frem 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ysici		Decedent's Name (First, Middle, Last)			Deta of Deet Month	h Day	Year	3. Tima of Death
Medic		Gordon Robert Handler		The state of the s	anuary		998	4:20PM
camir		4a. Facility Nama (If not institution, give street end number)		City, Town, or Locati	on of Death	4c. County	of Death	
		St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		altimore Undar 24 Hrs. 8	Date of Birth		0.00	(0)
eral ector				Hours Min.	Date of Birth (Month, Dey, uly 27	, 1946	9. Birthpi Count MD	ace (Stete or Fore try)
del	_	10a. State 10b. County 10c. City, Town or Local	ition				10	Od. Inside City Llm
offile	Director	MD Carroll Sykesville	e 10f. Zip Code					t Yas 2□!
r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at	Dir	10e. Street and Number 300 Maes Ct.		1	0g. Citizen of W USA	Vhat Coun	try?	
	Funeral		21784 as Dacedent of Hispa res, specify Cuban, M	anic Origin? (Specify	Yas or No-			an Indian,
	b	1 Never Married 2 Married 1 Yes 2 No	3.7	Mexican, Puerto Rica pecify:	an, etc.)	Specify.	k, White, o	
	eted	15. Decedant's Education 16a. Deceden (Spacify only highest grade completed) (Give kin	nt's Usual Occupetion nd of work done durin NOT use ratired)	n na most of working		16b. Kind of Bu	siness/Ind	lustry
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)				TDG		
H		17. Fether's Name (First, Middle, Last)	Manager 18	Mother's Name (Fi		IRS	(a)	
	To Be	Gordon Francis Handler	10.	Esther P	e (First, Middle, Maiden Sumeme)			
	-		Address (Street end			City or Town,	Stete, Zip	Code)
		Mrs. Leslie Handler (wife) 300 Ma	es Ct., Sy	ykesville	, MD	21784		
		20a. Method of Disposition 1	ion (Neme of tory or other pleca)		ate	20c. Location -	City or To	wn, State
		4 □ Donetion 5 □ Other (Specify) Crest Lawn				arriott		
once.		21. Signature of Funeral Service Licansee per VR 22. N Paige maignt herbert PO	Name and Address of Box 195,	^{f Facility} Haigh Sykesvill	ight Funeral Home & Chapel			
is the bur	Medical Examiner	Dua to (or as e conseque	1100 01).			1	1	
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בייניין, ליפעמ ב פוניטים כס מפומגיוסם יכן נטמ מט וויפ	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest Dua to (or as a consequence of the conditional contributing to death but not resulting in the underlying to death but not resulting in the underlying examiner? Hospital: Disease or injury that initiated avents resulting in deeth but not resulting in the underlying to death but not resulting in the underlying examiner?	nce of): erlying cause given in	n Part I.	23b. Did to 1 Ve 24a. Was au perform 12 Ye heck only on 5 Reside	bacco use con es 2 No n autopsy ned? es 2 No e)	24b. We ava cor of c	pably 4 Unknown autopsy finding autopsy finding allable prior to mpletion of causa deeth?
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tha funeral director, paga 2 should be detached for usa as the	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Lest Dua to (or as a consequent of Lest) Part II. Other algnificent conditions contributing to death but not resulting in the underlying examiner? A Yes 2 No	ance of): 26 3 DOA Other: 4 Work? 1 Yes t, factory, office 29c. Licansa nut	5. Plece of Death (C. 4 Nursing Home 28d. 2 No 28f. No. dete and placa, and on, death occurred e	23b. Did to 1 Ye 24a. Was an perform 12 Ye beck only on 5 Reside Describe ho in & m ring C Location (St. City or Town rthwes due to the cap the time, da	bacco uae con es 2 No n autopsy ned? es 2 No ee) enca 6 Othe own furnor catheter reet end Number, stete) st Hospi ause(s) end Re ate and place, e 9d. Data signed 1-9-	atribute to 3 Prob 24b. We ave correctly ave correctly ave correctly ave ave correctly ave	re autopsy finding ullable prior to impletion of causa deeth? I Yes 2 No Chioceph perforate placem? Route Number, Center, the cause(s)
paga 2 should be detached for usa as the	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest Dua to (or as a consequent of Lest) Part II. Other algnificent conditions contributing to death but not resulting in the underlying axaminer? Hospital: 1 Inpatient 2 ER/Outpetient 1 Injury (Month, Dey Year) 1 Natural 5 Pending investigation 12-26-97 Unk. 28a. Place of Injury - At home, farm, street building, etc. (Specify) HOSpital 29a. Centilier 1 Certifying Physician: To the best of my knowledge, deeth or and menner stated.	nce of): 26 3 DOA Other: Work? M 1 Yes t, factory, office ccurred et the time, distigation, in my opinio 29c. Licansa nu	5. Plece of Death (C. 4 Nursing Home 28d. 2 No 28f. No. dete and placa, and on, death occurred e	23b. Did to 1 Ye 24a. Was an perform 12 Ye beck only on 5 Reside Describe ho in & m ring C Location (St. City or Town rthwes due to the cap the time, da	bacco uae con es 2 No n autopsy ned? es 2 No enca 6 Othe ow Injury occurr actheter reet and Number, steel Steel suse(s) end ne ate and place, e	atribute to 3 Prob 24b. We ave correctly ave correctly ave correctly ave ave correctly ave	re autopsy finding ullable prior to impletion of causa deeth? I Yes 2 No No Chioceph perforate placem? Route Number, Center, the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth RODNEY K. HANSEN DUMM130 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE | Months | Deys | Hours | Min. | 8 Dete of Birth (Month, Dey, Year) | 1 - 2 0 - 1 9 3 3 5. Social Security Number 9. Birthplece (State or Foreign Country) CALIFORNIA 7. Age (In vrs. last birthday) 1 MM 2 F Months 64 Yrs. 563-40-5187 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1311 PARK AVE. 21217 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status

1 ☐ Yes 2 MNo Specify:

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

MUSICIAN

Bleck, White, etc.

WHITE

Approximete Intervel Between Onset end Death

3 Probably 4 Mhknown

24b. Were eutopsy findings evelleble prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Specify.

16b. Kind of Business/Industry

MUSICIAN

18. Mother's Neme (First, Middle, Meiden Sumeme)

LILLIAN G. FULTON

Baltimore, Maryland 21215-0020 Mantal N Department of Health an Important: If Item 27 is Pagest 1 **Physician** /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

1 Never Merried 2 Married

15. Decedent's Education (Specify only highest grede completed)

5+

College (1-4or 5+)

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondery (0-12)

17. Father's Name (First, Middle, Last)

HARRY OSCAR HANSEN

19a. Informent's Neme/Relationship (Type, Print)

Funeral

Director

must be notified at

"natural", or items 23a or

Director

Funeral

by

Completed

0

5 signed t page 2 s certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifice etely filled in by the funeral director. 24 hours Medical To the within 2
To the complete

P.O. Box 68760. Physician/Medical Records, p Completed Division of Vital Be Certification: To

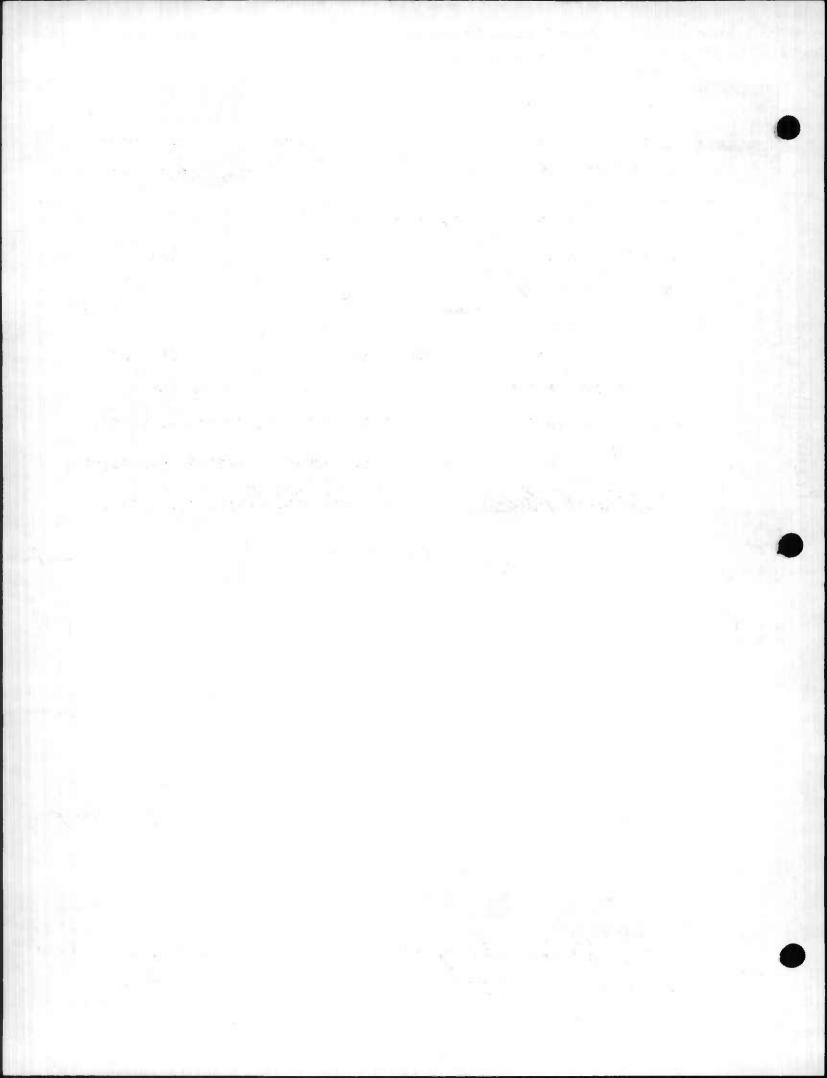
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LEANNE BECK (NIECE) 11740 TESLA RD. LIVERMOR, CA. 94550. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY01/21/98 BALTO., MD. 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. elliano 4905 YORK RD. BALTO., MD. 21212. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Immediete Ceuse (Fine disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Wes en eutopsy performed? 2000 1 Yes 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29b, Signature and titl 29c. License number 29d. Dete signed (Month, Dey, Year) N. Charles St Bults, md 30. Name and eddress of person who completed cause of deeth (flem 23a) (Type, Print)

GBMC

32. Registrar's Signature

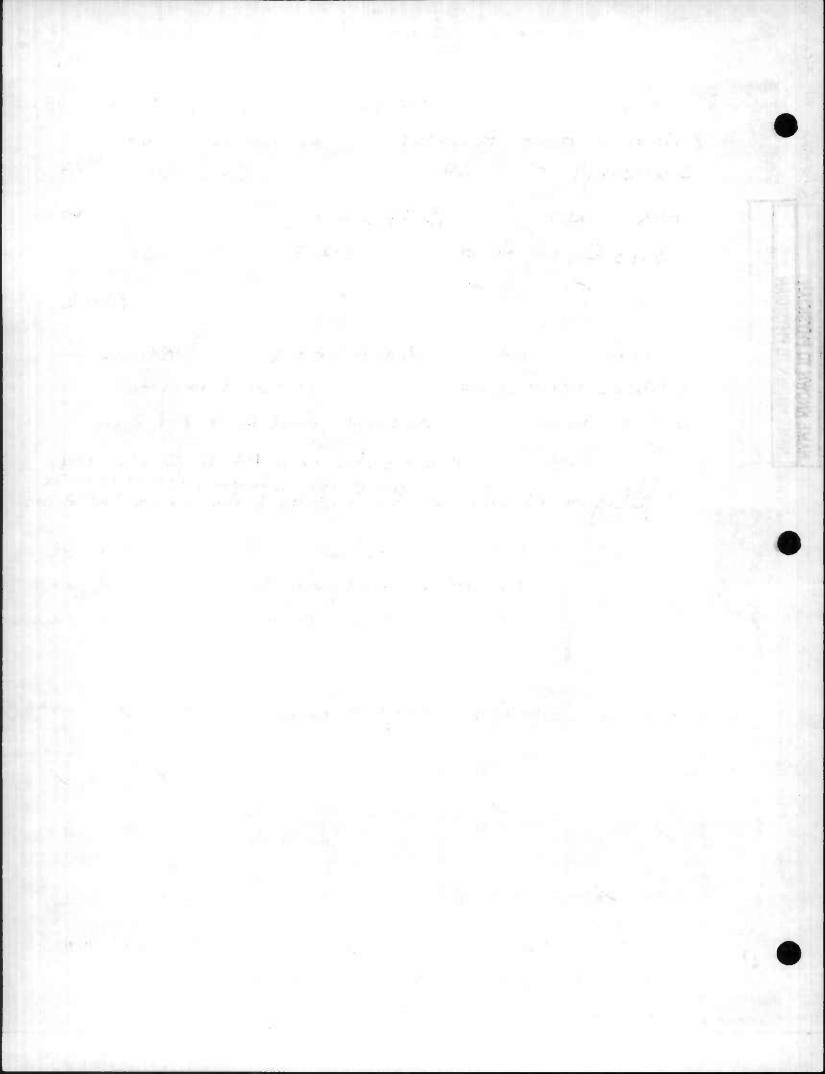
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month CHARLET HENDERSON Janvam /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b City, Town, or Location of Death 4c. County of Deeth Examiner HOSριtal
7. Age (In yrs. last birthday) Baltimore hurch LOWE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 60 Months Deys 1 M 2 F 225-32-0019 Director Yrs Jct. 28 1928 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore 1 THES 2 No NA Director or 28s-f 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code Road 21215 Name 23a 3613 19/90 USA Funeral Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 No Blac by 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) pholoterino ACM 10 Mental Hygia marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Bessie haeles tender son 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Plece of Disposition (Name of cemetery, crematory of other place) Road Balto. item 27 iola Hendreson-wife 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 1.29.98 4 ☐ Donetion 5 ☐ Other (Specify) ten. 22. Name end Address of Facility
WmC. March 21. Signature of Funerel Service Licenses Home West INC funeral 4300 Wabash Are Md 21215 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart feiture. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) KESPIRATORY week. Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 hoan Physician/Medicai Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? peeu page 2 s 2 1 No certificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice stely filled in by the funeral director, i 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Certification: To 1☑Inpatient 2□ ER/Outpetient 3□ DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di complately filled in 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. edicai 29a. Certifier (Check only one) 29b. Signature end ttle of certifier 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Clarence SARKODET - Abov, Church Church 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** HOLDEN Month IRVIN /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltinore If Under 24 Hrs. 8. Date of Birth KNOI RVING Got 5. Sociei Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 F Days 49 Yrs. 219-50-0781 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ineide City Limits 7 is marked other than "natural", or items 23a or 28a-1 show traumatic evant, the Modical Examiner must be notified at Baltimore NA 1 19s 2 No Director Ma 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 2-12 BROSE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritai Status pernit. Peges 1 and 2 should be filed within 72 hours after Department of Haalth end Mentel Hygiena. important: If item 27 is marked other than "natural" or hanny Injury or other traumate. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced lac Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA 121 SEKEEDER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be ANNIES Walter G. Holden SAVAGE 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Holden-wife 20b. Pleca of Disposition (Neme of cemetery, crametory or other plece) 3415 5 MARGRETTA Palto Md 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 29.98 4 ☐ Donetion 5 ☐ Other (Specify) Temoria 21. Signature of Funeral Service License Home 4300 Wabash 23a. Pert . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Physician Sopticomia /Medical fmmediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last P.O. Box 68760, Physician/Medical Pert II. Other elgnificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 3 ☐ Probably 45 Unknown 1 Yes 2 No Records, à 8 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; p 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Medical Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

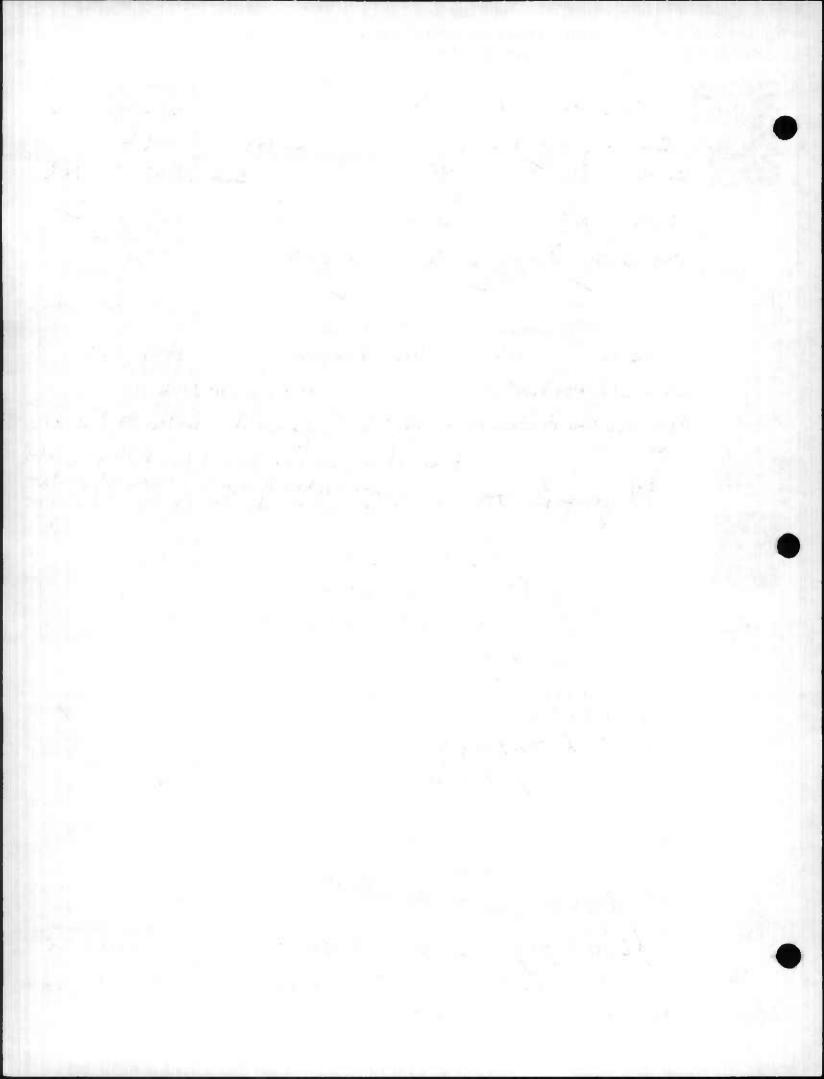
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name, end eddress of person who completed cause of death (Item 23e) (Type, Print)

2300

Garrison Blud Balto MD 2/3/16

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State Registrar 31. Dete filed (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 22, David Birney Hand 4:30am 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 1002 York Lane If Under 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Sacurity Number 7. Age (In vrs. lest birthdev) Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Dev. Yaer) Months Days 15₹M 2□ F 133-16-2453 92 California Nov. 24, 1905 Usual Residence of Decadent 10c. City. Town or Location 10b. County 10d Insida City Limits 1 Yes 2 No Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21403 1002 York Lane 12. Was Dacadant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Naver Married 2 Married 1 Yes 2 XNo Specify: USA Specify 3 XWidowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Bio-Chemistry College Professor 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Bertha Hartshorne Clifford B. Hand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) P.O. Box 951, S. Orleans, MA Sylvia Pott - Daughter 02662 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other pleca) 20c. Location - City or Town, Stata 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 1/22/98 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21401 12 Ridgely Ave. Annapolis, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia 1 week disease or condition resulting in death) Due to (or as e consequence of): Congestive Heart Failure 1 Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequenca of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Degenerative Arthritis 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Bereavement 1 ☐ Yes 2 XNo 1 TYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

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items 23a

nit. Pages 1 and 2 should be filed within 72 hours efter death end wental Hygiene.
ortant: If item 27 la marked other than "natural", or Itema 23 Injury or other treumatic event, the Medical Examine mass

permit. Page Depertment Important: If

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

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physicia 9SF deteched signed by the peed hes

page 2 certificete or Attanding Physician: director, this funeral After efter death.

Division of Vital Records, P.O. Box 68760,

completely To the within 2

Hospital 24 hours

S. Rhodes Paul 31. Date filed (Month, Day, Year) State

29a. Certifier

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27 1998

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

28e. Date of Injury (Month, Dey Year)

M.D.

Julia Aguistrar's Signature Julia Aguidson-Mandale

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Tima of

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

D22028

29c. Licansa number

1 Yes 2 No

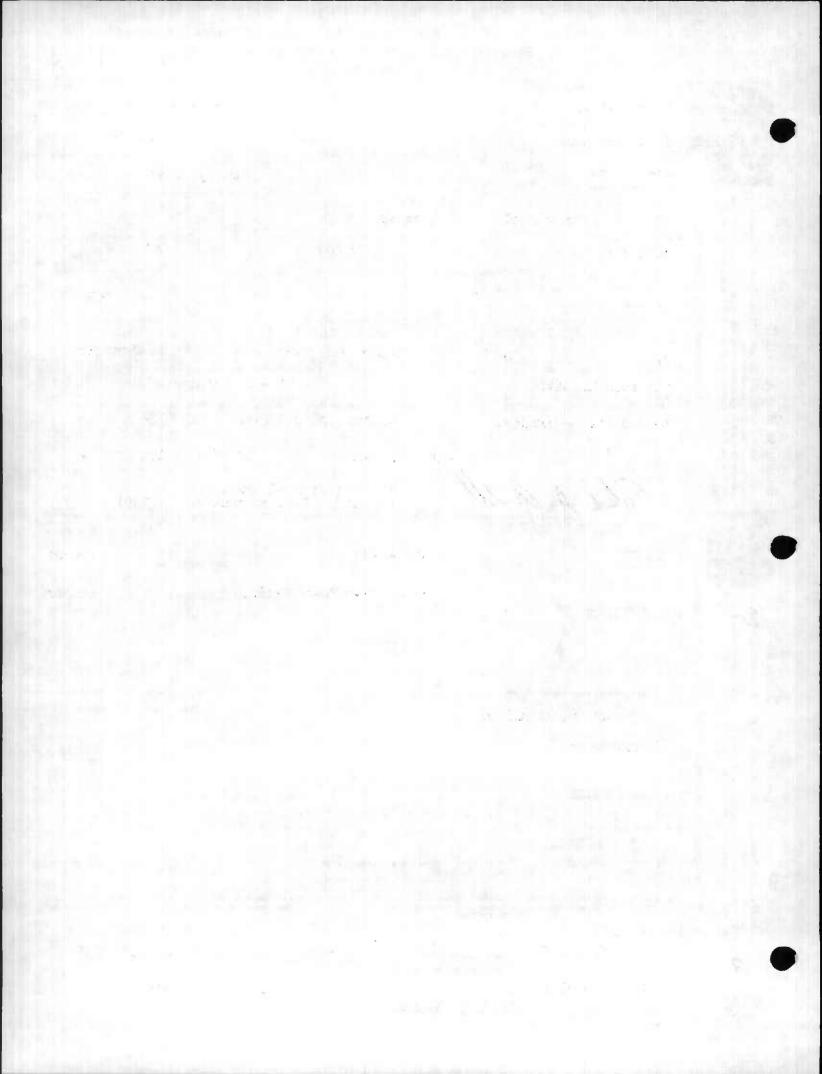
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Crofton, MD 21114

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item: 19b, per F.H. G-755 1/27/98 reb Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Year **Physician** Wolfdang Hannes

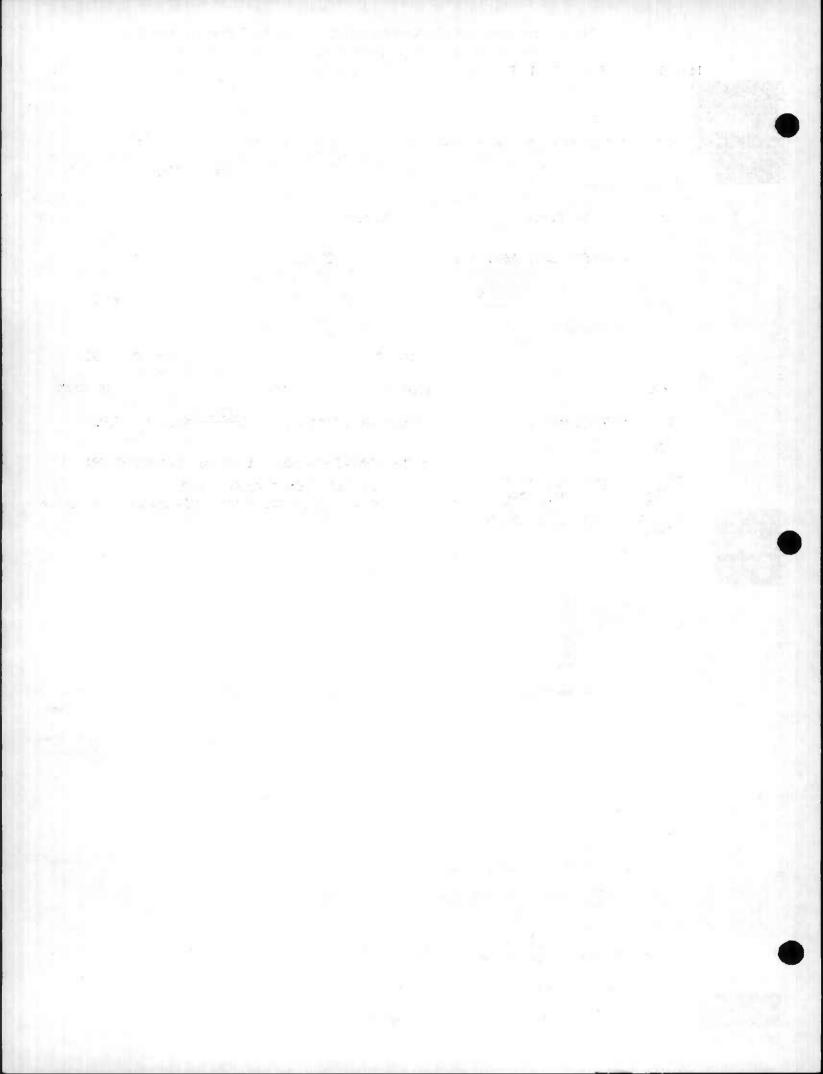
4e. Fecility Name III not institution, give street end number) 3:40PM 23 January 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Hospital of Baltmore N/A If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) OCT 5, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthplace (Stete or Foreign **Funeral** Months 1 € M 2 □ F Deys 86 130-05-3984 Yrs. GERMANY Director Usuel Residence of Decedent Maryland 10a, State 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s4 show other treumstic event, the Ned cal Exam for must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 No BALTIMORE with the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 725 MT. WILSON LA., APT. 420 Funeral 21208 USA death 12. Was Decedent Ever in U,S.
Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. Pages 1 end 2 should be filed within 72 hours eftar nent of Health and Mantal Hygiana. Yes 2 No 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 ₩idowed 4 Divorced Yeer or Dates Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) OWNER GROCERY STORE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 FRITZ HANNES FLORA STUDENT of Health and Nitem 27 is mar 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

\$1EVENSON

NACIREMA LANE

BALTIMORE, M D 21153 19a. Informent's Name/Relationship (Type, Print) JUDI HANNES (DAUG.) Saltimore, 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removel from State 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, State permit. Pages
Depertment of I
important: If ite
any injury or ot
once. cemetery, crematory or other piece) 4 ☐ Donetion 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 1/25/98 RANDALLSTOWN, MD 23-Signature of Funeral Service Lig 22. Neme end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 24a Part1. Inter the disease, or complication that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, in heart failure. List only one cause on manufine. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Sepsis Ore month diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest for use as the bunel-tran Due to (or es e consequence of): Box 68760. attending physician Due to (or es a consequence of): P.O. I detached Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? peen has paga 2 certificate 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 € Inpatient 2 □ ER/Outpetient 3 □ DOA After this Director: After third in by the funaral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division Attanding 5 Pending investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide after 0 To the Hospital o Within 24 hours at To the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Johnson 23 AS 2402321PG 9024 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ,0 Hospital of Baltmare Baltmare Sinai Jatrice Green 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Julia Davidson-Randall JAN 27 Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Hart Florence Ellen Dav Month Year **Physician** 9:50 Am 23, 1998 January /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** N/A Baltimore 1706 Charlotte Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
May 31, 1948 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months Hours 1 M 2 F Maryland 49 Yrs 212-46-8481 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours effer deeth with the Meryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any or other traumatic event, the Medical Evaluation must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Yes 2 No Directo Baltimore City N/A Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21224 United States 1706 Charlotte Avenue Funeral 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XXNo
If Yes, Give
Year or Dates: Never Married 2 ☐ Merried 1 Yes 20No Specify: Baltimore, Maryland 21215-0020 Specify. White Py 3 Widowed 4 Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Accounting 10 Years Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angeline Peters Carl Hart 2 19a. Informant's Name/Relationship (Type, Print) Friend 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21224 Carolyn Willis 1706 Charlotte Avenue 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition

☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Date 20c. Location - City or Town, State permit. Page Depertment of Important: If any Injury or once. 1/26/1998 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Junial Segment (cons Oak Lawn Cemetery Aral Segice Licens 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on **Physician** /Medical Immediate Cause (Final Colon Concer situteent disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician end the buriel-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): ettending p 98 23b. Did tobacco usa contributa to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given In Pert I. been signed by the should be detached 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed his certificete has but director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □Other (Specify) this funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of After 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours efter death. To the Funeral Diractor: A completely filled in by the fu investigation 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of carriller 29c. License number 29d. Date signed (Month, Dey, Year) 40 Du a Im 23 D40854

BW

State Registrar Durid A Rusebers, M.

31. Date filed (Month, Dey, Yeer)

JAN 27 1998

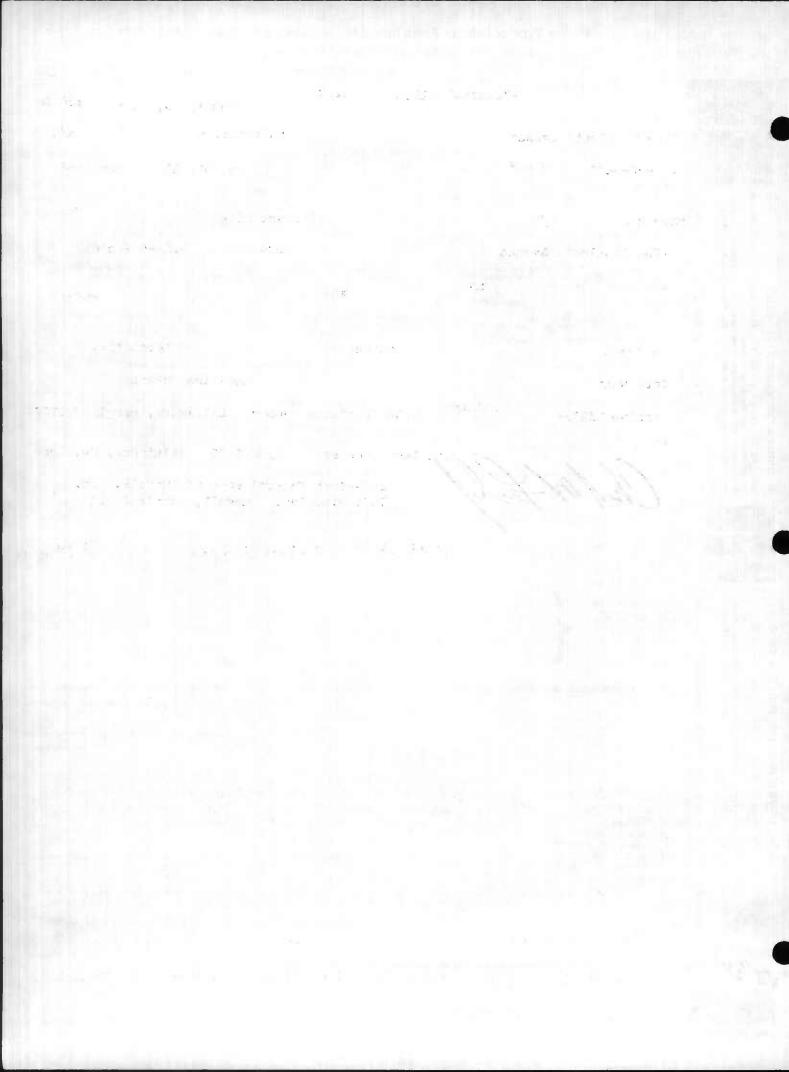
32. Registrer's Signature desired and desire

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signature

Baltmere, MD

21202



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1998 18:44 JANUARY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** HOSPITAL NORTH ARUNDEL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 1D M 2□ F 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 218.05.7670 Yrs Director MARYLAND Usual Residence of Decedent 10e Stete 10b Count 10c. City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No ASad Director eno 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Example: Francis 23a or 526 Funeral filed within 72 hours after death Wes Decedent Ever Williams Armed Forces?

1 Yes 2 No W W

If Yes, Give
Year or Detes: ARMY Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) edent Ever in U,S. 1 Never Married 2 ☐ Married "natural", or à WHITE 3 Widowed 4 □ Divorced Completed other than "natur 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education fy only highest grede completed) W (0-12) College (1-4or 5+) e (First, Middle, Lest) 18. Mother's Name (First, Be Pages 1 and 2 should be lotte 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2106 / 19e. Informent's Name/Reletionship (Type, Pnint) important of Health are important if them 27 is any injury or other traum ENZ homas Method of Disposition

1 Burial 2 Cremetion 3 F

4 Donetion 5 Other (Specify) 20c. Location - City or Town, Stete 3 Removal from State em Someture of Funerel Service License Part 1. Enter the disease, or conshock, or heart failure. List only **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 60 minutes Examiner Examine Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest Due to (or es e consi Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence of). Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Wes case referred to medical examiner?

1 Yes, 2 No Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpetient 2 ☑ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No Director: / 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 Homicide in 24 hour.
The Funeral Direction in the fulled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

NORTH ARUNDEL

GLEN BURNIE

mD

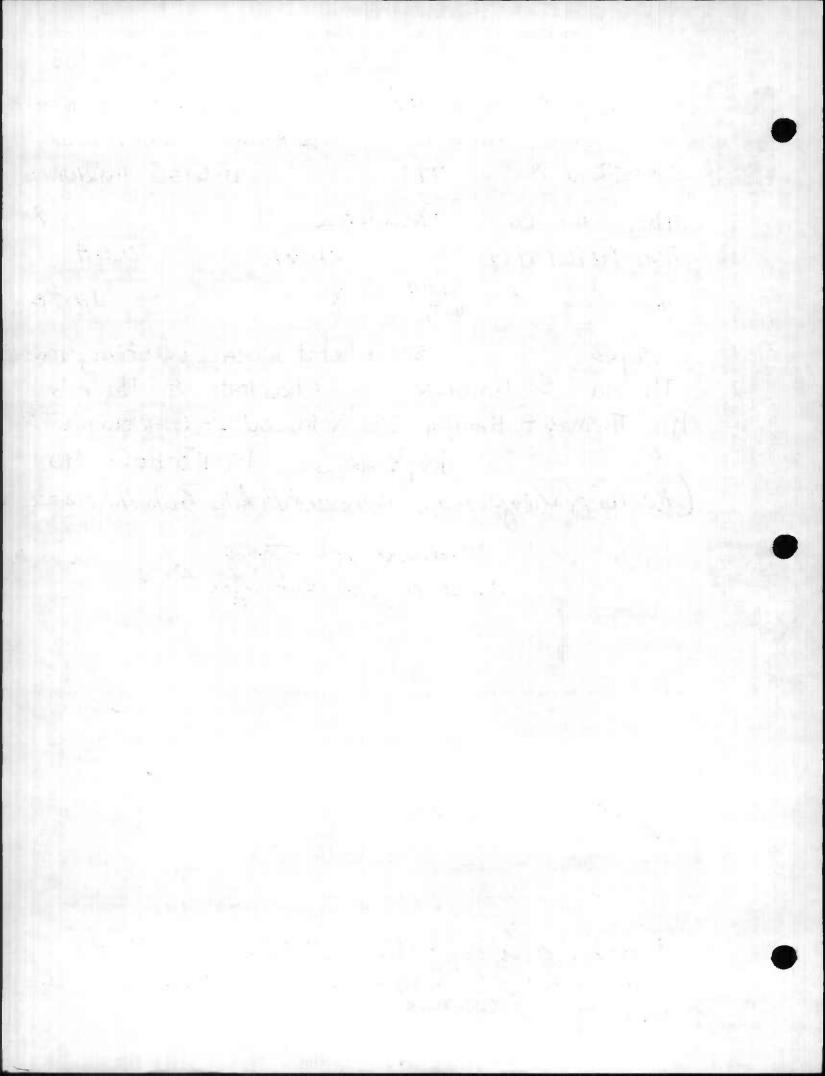
me engladdress of person who completed cause of death (Item 23e) (Type, Print)

mD

RAMIREZ

31. Dete filed (Month, Day, Year)

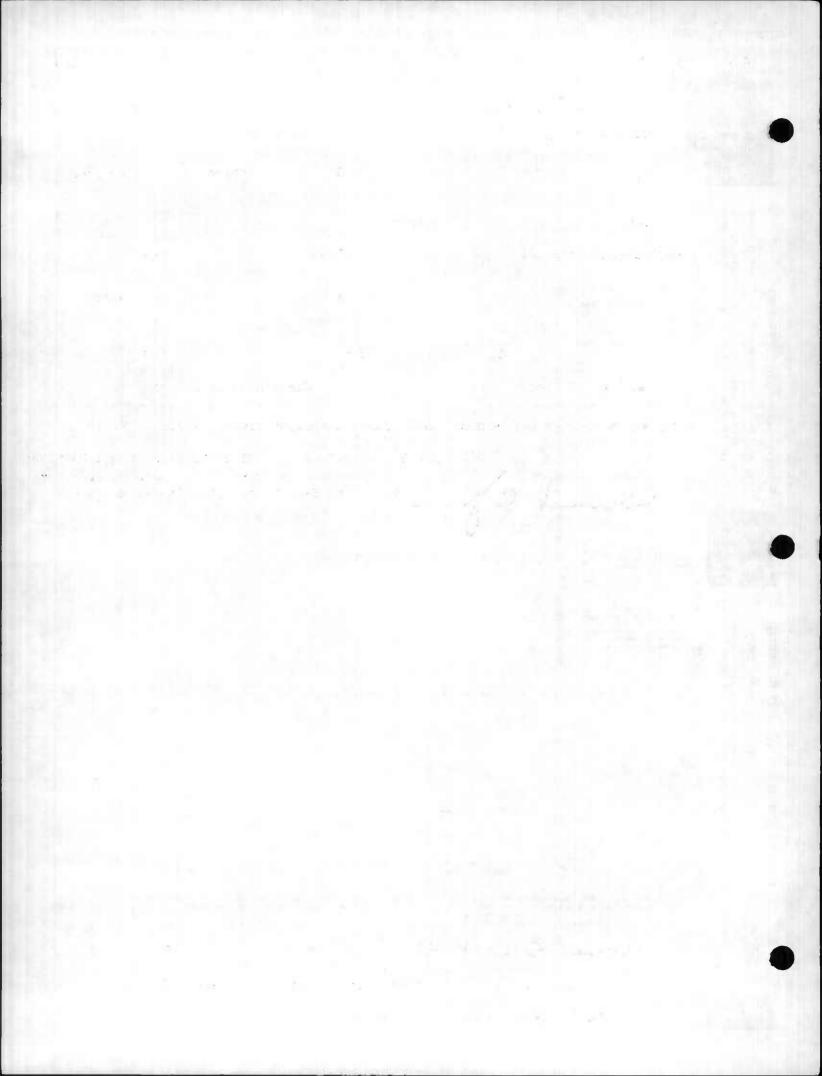
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene DAVONTAY JACKSON Certificate of Death Items: 23a part I,27 per MEO G-757 3/5/98 dh Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Dey Month **Physician** Davontay Keshawn Jackson JAN. 23, 1998 1303 PM /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SINAI HOSPITAL E.R. BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) 5. Sociel Security Number Birthplace (Steta or Foreign Country) 6. Sex 1M M 2□ F 7. Age (In vrs. lest birthdev) **Funeral** Days Yrs. 0 NONE Director 09/24/97 Maryland Usual Residence of Decedent the Manylend 10a. Stata 10b. County 10c. City. Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at 1 Yes 2 □ No Directo Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4909 Queensberry Ave 21215 USA Funeral death 12. Was Decedant Ever in U,S. Armad Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health end Mantal Hygiene. Important: If Item 27 le merked other than "natural", or itel many lollury or other traumatic event, the Medical Examples any Injury or other traumatic event, the Medical Examples. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middla, Last) Samuel L. Jackson Donna Michele Johnson 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Elizabeth H. Jackson/ Mother 5409 Jonquil Ave., Baltimore, Maryland 21215 altimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Date 1 Burial 2 Cremation 3 Removel from State Cedar Hill-Babyland 01/29/98 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 23a. Pert1. Enter the disease, or complications that an use the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one Approximate Intervel Between Onset and Death Physician Immadiete Ceuse (Finel disease or condition resulting in death) /Medical SUDDEN INFANT DEATH SYNDROME Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest physician and the burial-tran Due to (or es e consequence of): certificate be axec Box 68760 Physician/Medical Due to (or es e consequenca of) as usa 50 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings availabla prior to completion of cause of death? Completed 24a. Wes en eutopsy peen page 2 1 ¥ Yas 2 □ No 1 ¥ Yas 2 □ No certificate director. Be 25. Wes case referred to medical axaminer? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient XX ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) XYes 2□ No P this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 (X) XJatural 5 Pending eftar deeth. Director: Aft 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Nospital 124 hours e Funeral C 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end menner as stated.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune complately fi (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number lonald & Wight MD O.C.M.E JAN. 24, 1998 30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print) G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 DONALD 31. Dete filed (Month, Dey, Year) 32. Ragistrar's Signatura State Julia Davidson Marchall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Menth **Physician** JACKSON 1987:00A,M JASPER Jamay 20 /Medicai 4a. Facility Name (If not institution, giva straat and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Lew BURE If Under 24 Hrs. ARUNDEL HOSPITAL ARUNdeL ANNE 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 158M 2□ F Months Days Hours Min. 257 32 5572 83 Yrs. Director Aug. 19, Georgia Usual Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 ☑ No Anne Arundel Maryland Marley 10e. Street and Number Millennium Nursing Home 10f. Zip Code 10g. Citizen of What Country? 0 or items 23s 7577 N. Howard Road 21060 U.S. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yas or No-It Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed withIn 72 hours after 1 ☐ Yes 2 X No It Yes, Giva 1 Never Married 2 Marriad 1 ☐ Yes 2 No Spacify: Baltimore, Maryland 21215-0020 by White 3₺ Widowed 4 Divorced "netural", Year or Dates: Be Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry l Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) United Steelworkers Steelworker 3rd marked other 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnema) Health and Mentel Tennie McGee J. L. Jackson 20 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 is m any injury or other traum once. Martha Garber daughter 38 Mapledale Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 1/22/98 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltin propolections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one ceuse on each line. Baltimore, Md. 21225 una Part1. Enter the disaase, or shock, or heart failure. Line Approximate Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPTICEMIA Examiner Due to (or as a consequence of): Physician/Medical Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 the Dua to (or as a consequence of): 98 to P.O. 1 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to Completed 24a. Wes en autopsy peed completion of ceuse of death? page 2 certificate hes 20 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Diractor: After this certifics completely filled in by the funeral director, I 25. Was cese referred to medical examiner? Be 26. Place of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 21 No 1 Yes Inpatiant 2 ER/Outpatlant 3 DOA er of Death Date of injury (Month, Day Yaar) 27. Men 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) 20 MA

Glen Serenie. mD. 21061

State Registrar 30 Neme end address of person who completed cause of death (Item 23a) (Type, Print)

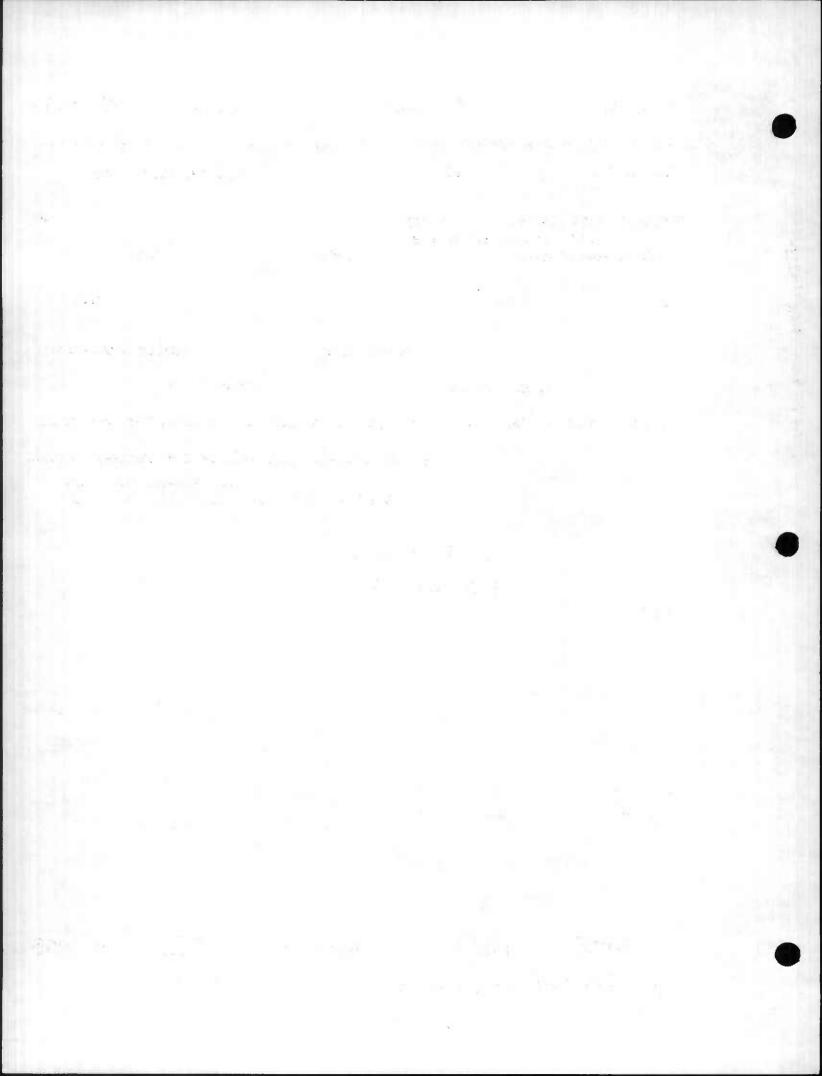
GRETHA

31. Dete tiled (Month, Day, Year)

JAN 27

HOTEL ARIVE

32. Registrar's Signature



1. Decedant's Name (First, Middle, Last)

Betty C. Kozlowski

5. Social Security Number

4a Facility Nama (If not institution, give straat and number)

NORTH ARUNDEL HOSPITAL

7. Age (In yrs. lest birthday)

Physician

/Medical

Examiner

Funeral

|--|

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sept 4, 19. 1 □ M 2/2 F Yrs. Maryland Director 213-32-5872 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ☑ No Director Crownsville Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 708 Latham Drive 21032 USA Funeral 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes ② No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 0 1 Yes 2 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental H Is marked of Joseph Sears Elizabeth Jones 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health ar tem 27 Is other tra 708 Latham Drive, Crownsville, MD John W. Kozlowski - Spouse 21032 20b. Place of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/98 Crownsville, MD Maryland Veterans Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, alak 21401 MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Examiner Collapse due to Sepsis Cardiovascular Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Physician/Medical Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? tract bleeding 1 Yes 2 No 3 Probably 4 Unknown Gastrointestinal þ 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Numbar or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medical 29a. Certifian (Check only one) 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifiar Shery Elassal, M.D. Be 5333 644 January, 25, 1998 10 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) North Aroundal Hospital 301 Hospital Drive Glen Burnie, MD 21061 Sherif Elassal 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State whia Day Son Randall. Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

4b. City, Town, or Location of Death

GIEN

JANUARY 25 1998

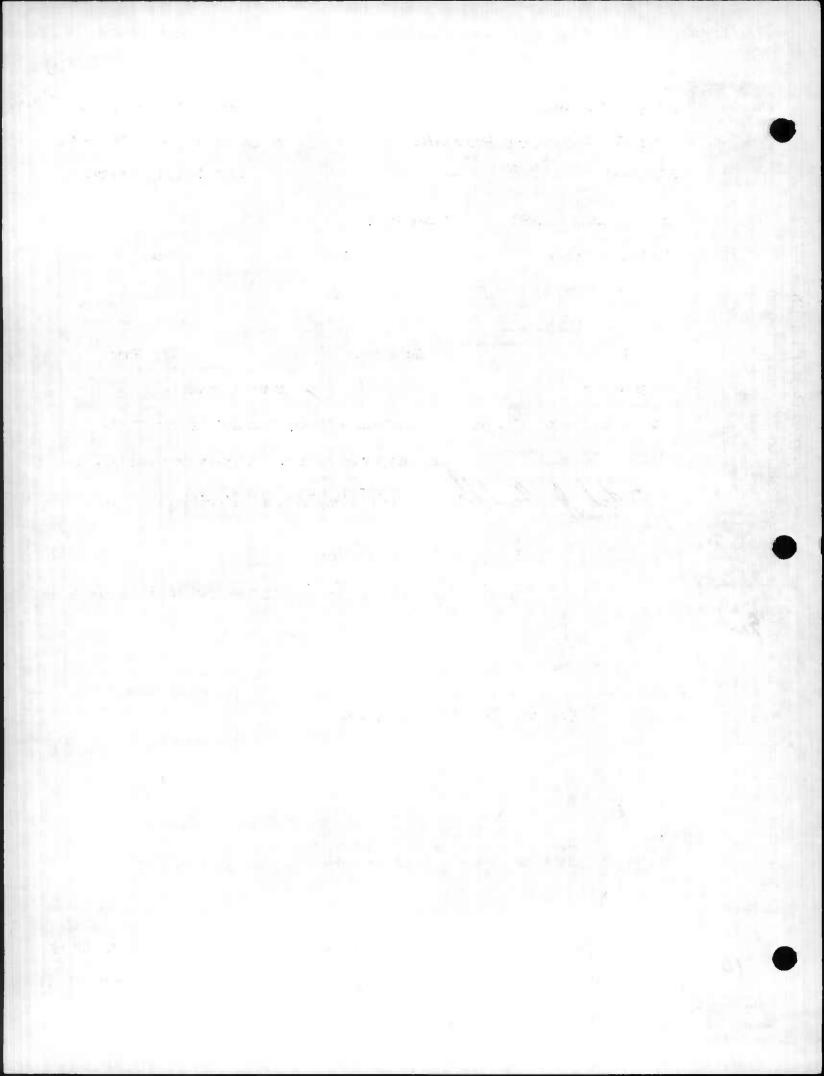
BURNIE ANNE ARUNDEL

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

3.30 PM



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physiclan** Charles Kirchheiner, Jr. January 24, 1998 4:00 pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Harford Gardens Nursing Center Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1X M 2□ F Months Deys Hours Yrs. Director 213-38-6464 July 19,1905 | Maryland tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No the Medical Examiner must be notified Director N/A Maryland Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 6 daath with 'natural', or items 23a 5115 Harford Road 21214 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🌠 No if Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11. Marital Status Black, White, etc. 72 hours eftar 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorcad White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) I Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) 5+ Chiropractor Medical/Health 17. Fether's Neme (First, Middle, Lest) permit. Pagas 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked oth any livity or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kirchheiner, Sr. Anna Dorothy Ortman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5115 Harford Road Mrs. Margaret E. Kirchheiner/Wife Baltimore, Maryland 21214 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 1/27/98 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee Brian A. Willem 22. Name end Address of Fecility Leonard J. Ruck Funeral Home, Inc. Buan a. Willen 5305 Harrford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Intervel Between Onsel end Death **Physiclan** /Medical Immediete Ceuse (Final Metastatu Corcionoma
Due to (or es e consequenca of): 18 mas disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were eutopsy findings eveileble prior to Completed 24a. Was en eutopsy completion of cause of deeth? page 2 s 1 Yes 2 MNo 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: '24 hours eftar death. Funeral Director: Atter this certifice ttaly filled in by the funaral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Complataly filled edicai 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) D210 d2 Q

State Registrar

31. Date filed (Month, Day, Year)

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Inth, Day, Year)

27 1998

July Registrar's Signature

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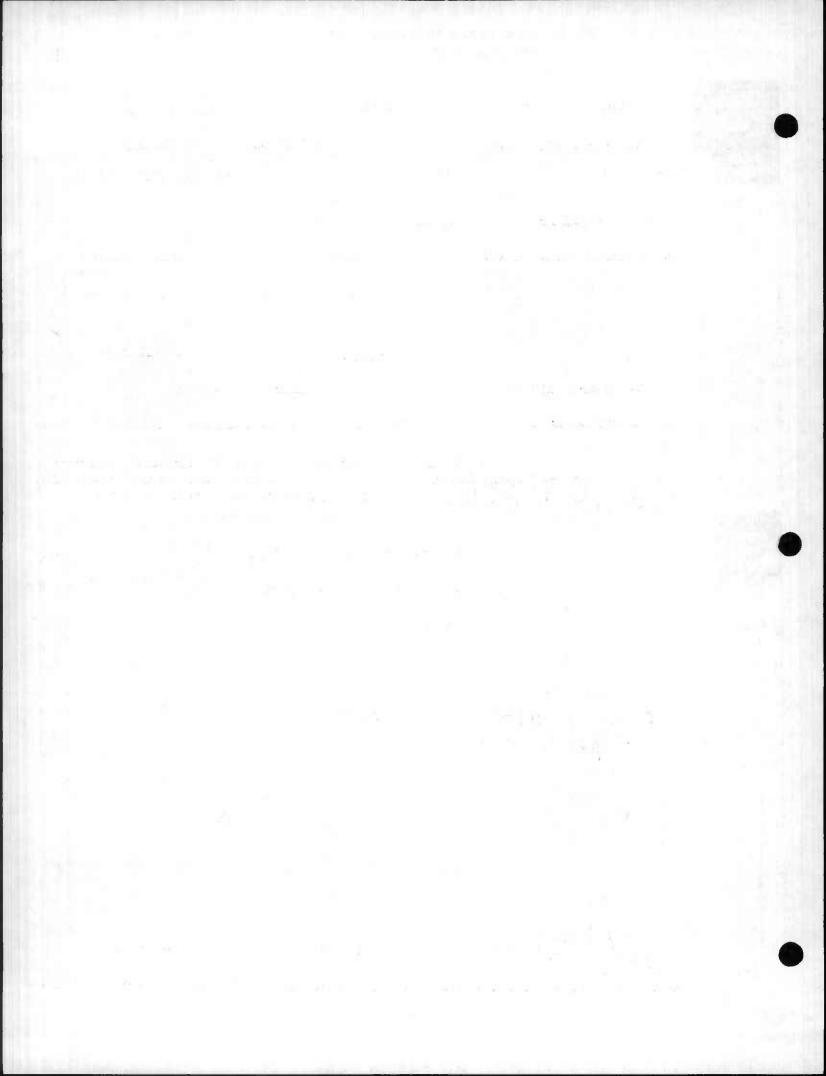
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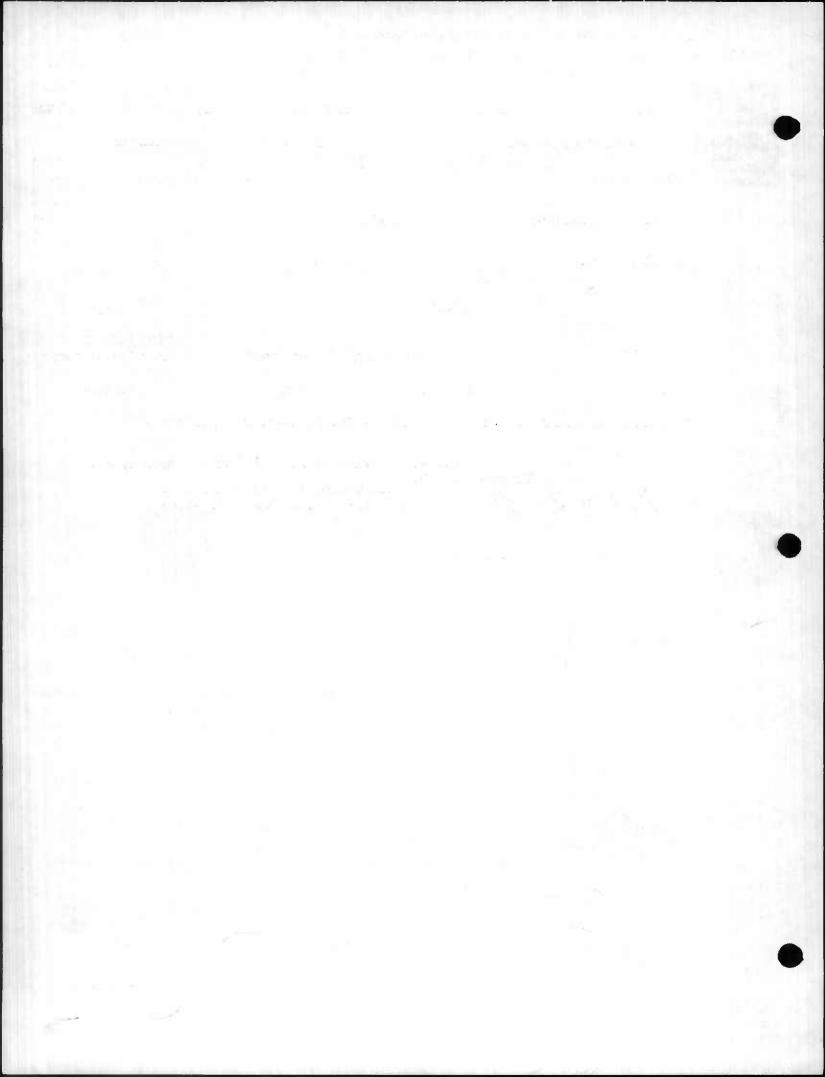
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ш	Director		215-09-4220	XXM 2□F		Yrs. Months Day	s Hours Min.	8. Dete of Birth (Month, Dey, March 1:	Yeer)	Country	y)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JANUARY CHARLES KAFKA 15, 1998 12:30AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 600 S. LAKEWOOD AVENUE BALTIMORE N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 □ F 90 Yrs. 218-01-2328 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits U Yes 2 □ No MARYLAND N/A BALTIMORE 10g. Cifizen of What Country? 10e. Street and Number 10f. Zip Code 600 S. LAKEWOOD AVENUE 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6 YEARS CARPENTER SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH KAFKA MARY ICHOLEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. PAULINE KAFKA 600 S. LAKEWOOD AVENUE BALTO. MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF JESUS 1-17 BALTO. CO. MD. 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME 23a. Part1. Enter the disease, or complications mal caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Respiratory ARREST Due to (or as a consequence of): Offuse Mesothelioma Due to (or as a consequence of): Immediate Ceuse (Final disease or condition resulting in death) Few HAURS Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONCONOMA 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Box 68760 Division of Vital Records, P.O. certificate # Affec

d or Attend after deat Director:

To the Hospital within 24 hours a To the Funeral Completely filled

Physician/Medical þ Completed Be

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

6 Items 23a

traumetic event, the Medical Examiner must be notified at

permit Peges 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. In team 27 is marked other than "natural", or Itema 23 any Injury or other traumatic event, the Nex Call Examiner mail

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

Certification: To 27. Manner of Death 29a. Certifier Medical 29b. Signature and title of certifier

1 Natural 2 Accident

3 Suicide

4 Homicide

State Registrar

31. Date filed (Month, Day, Year) JAN 27

5 Pending

investigation

6 Could not be determined



28a. Date of Injury (Month, Day Year)

NIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340/ E. PRATT ST Boltrinove, Md 21224

pulgeolor to mas

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

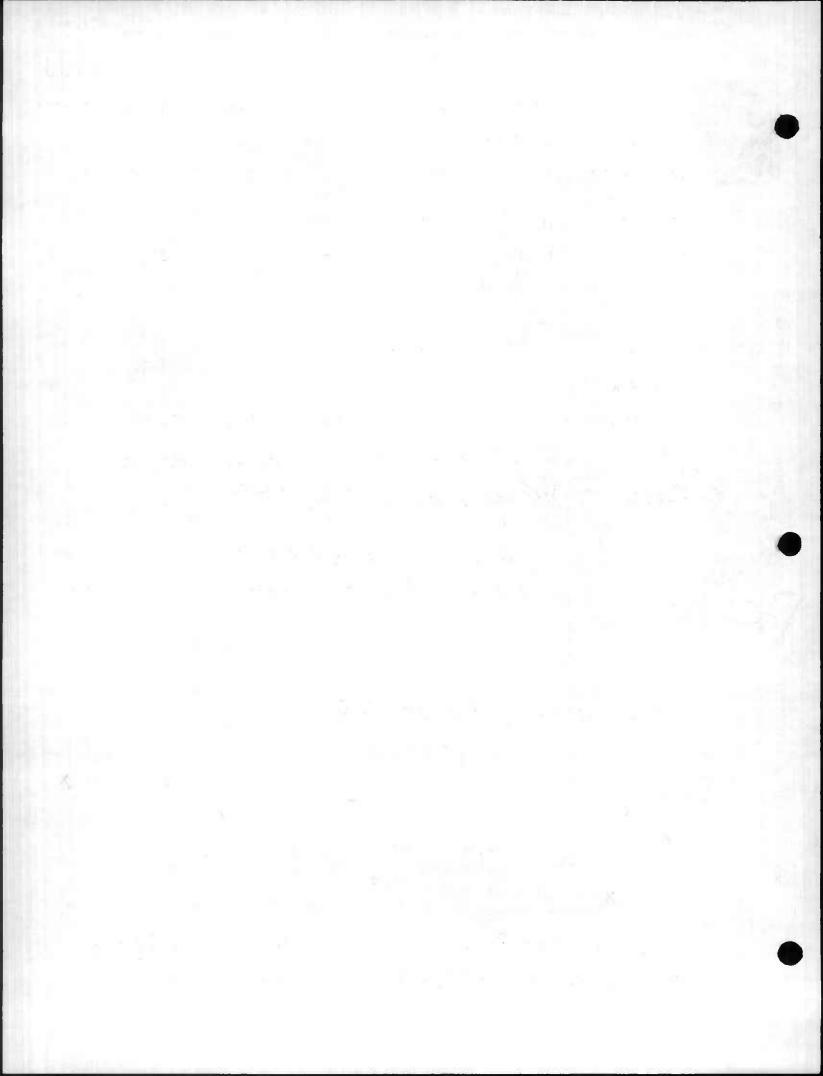
28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of Injury

NIA

28e. Place of Ihjury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month Dey **Physician** LANSON 0:45P STANLEY 1998 An /Medical 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner W. FrankLin Street NIA BALTIMORE Hours Min. 8. Dale of Birth 6. Sax 1 M 2 F 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Under 1 Year Birthpleca (Stata or Foreign Country) **Funeral** Days Monihs 51 24-46-7378 Yrs. Director mary/ AND Usuel Residence of Decadent 10c. City, Town or Location 10a. Siata 10b. County rai', or items 23a or 28a-f show Examiner owet be notified at 10d. Insida City Limits BAIHMORE 1 Yas 2□No Director Mary low #408 10e. Sireet end Number 10f. Zip Code 10g. Citizan of Whet Country? Panklin 21201 U5A W. 2 should be filed within 72 hours efter death vent Mental Hygiene.
Is marked other than "natural", or items 23, euralic event, its Medical Estimator. Funeral 12. Was DecedenI Ever in U,S.
Armed Forces?

1 ☐ Yas 2 SNo
If Yes, Give
Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stalus 14. Raca - American Indien, Bleck, White, etc. Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Completed by 3 Widowed 4 Divorced Block 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Private BusINESS Elementary/Secondary (0-12) College (1-4or 5+) YANITOR # grade treumatic event, 17. Falher's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Allester ChASE L. LAWSM 4. HARVOY 19a. Informent's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/30/ #408 BA/ HAVIE, Mary long / W. Franklin Strect Peges 1 end 2 ment of Health eant: If item 27 is ury or other tre Allester M. LAWSON NOTHER 20b. Pleca of Disposition (Nama of 20c. Location - City or Town, State 20e. Method of Disposition Data Depertment of Important: If Its any injury or o cemetery, cremetory or other piece) Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Canatary BAHLUK, Hary low 22. Name end Address of Fecility CHA 21. Signature of Funerel Service Licensee HAWIS TMAN 5240 REISTERShun CO IND 23e. Part Enter the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one ceuse on each line. Approximata Intervel Between Onset end Death **Physician** Immadiata Cause (Final disaasa or condition resulting in deeth) /Medical CARCINOMA MONTHS Examiner Due to (or es e consequença of) Physiclan/Medical Examine or Attending Physician: The law requires that the death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted avants resulting in death) Lest DU . Due to (or as e consequence of): P.O. Box 68760, Due to (or as a consequence of): use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown SQUAMOUS CELL CARCINOMA Records, by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed HYPERTENSION 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case reterred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Oulpelient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28e. Deta of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. injury et Work? 5 Pending investigation 1. Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours efter deal 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, streel, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 112 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

State

Registrar

within 2 To the ŝ

> ELEANIOR BEGUZMAN, MD 31. Date filed (Month, Dev. Yea

29b. Signature and title of certific

29a. Certifier

(Check only one)

Medicai completely

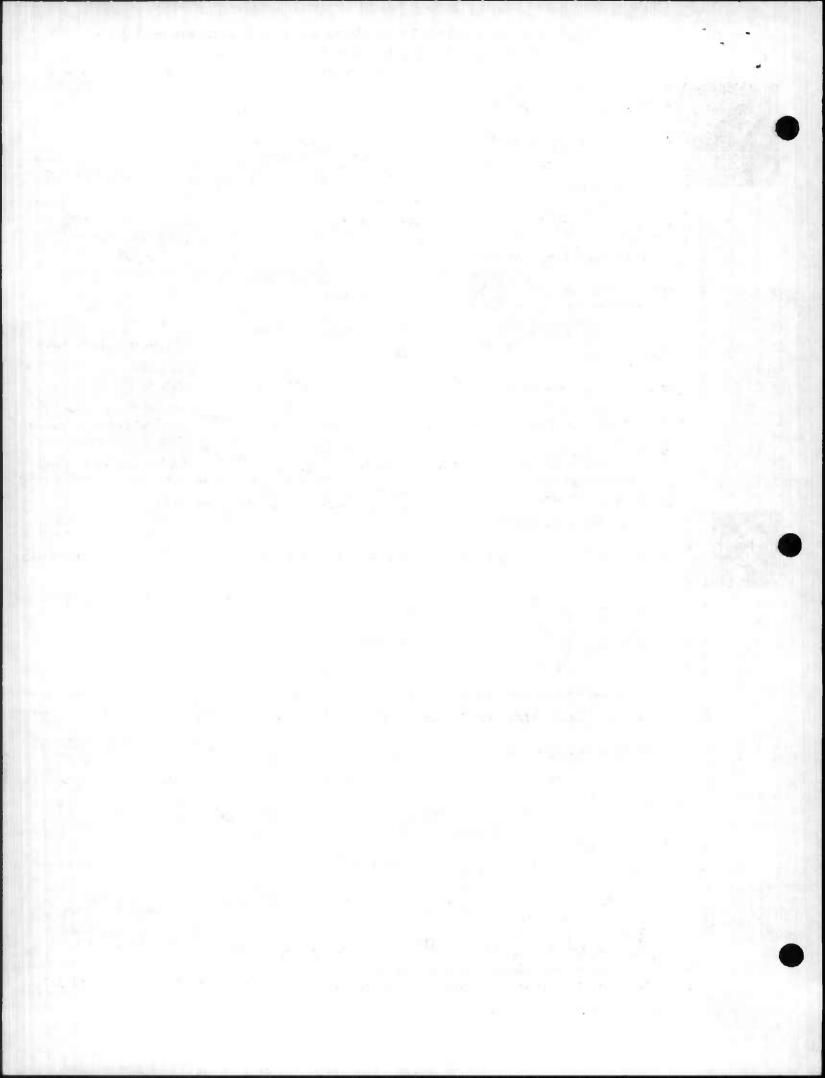
> UNIV. FAMILY PRACTICE, 29 S. PACA ST., BALTIMORE, MD ZIZOI June Handson Kandall

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. Licensa number

AU4176435D7897

29d. Date signed (Month, Day, Year) 1/21/98



State of Maryland / Department of Health and Mental Hygiene 8

Examiner must be notified at consistent and consist	A. Franklichters Manager der all	Rosalie A	\ Tan			2. Data of Da Month	ath Dey		3. Tima of Death
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene9Certificate of Death 1. Decadent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month 910/ LISPON - reddie Januar 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Centr Geriatric Baltimore Johns If Under 1 Year 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
Aug. 23, 1934 South Carolina If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Months Days 10 M 2 F 247-50-1335 Yrs. Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Md. N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 910 E.Biddle Street 21201 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Dacedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. 1 Never Married 2 Married **♣** No Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry $\overset{\text{Elementary/Secondary (0-12)}}{12th}$ College (1-4or 5+) Body and Fender Worker Automotive 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Lisbon Daisy Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Ellen Lisbon-Wife 910 E.Biddle Street Balto.Md.21201 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem.Gardens 1-29-98 Dundalk, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Caple Funeral Service 5502 Winner Ave. Balto. Md. implications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one ceuse on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final MOS disease or condition resulting in death) Multiple Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): hrombo em boli Mas Dua to (or as a consequence of) episodes MOS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown foromen Ovale 24b. Were autopsy findings available prior to complation of cause of death? Seizure 24a. Was an autopsy performed? Disorder Diabetes Mellitus Hypertension

25. Was case referred to medical axaminer? 2 00 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

by

Completed

Be 0

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natural", or frame 23a or 29= 4-4 any injury or other traumatic event, the Marketing.

or Attending Physician: The lew requires that the death certificate be

Physician/Medical Examiner þ Be Completed 10 Medical Certification:

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of cartifier

this certificate After deeth. within 24 hours efter deet To the Funeral Director: completely filled in by the

Division of Vital Records, P.O. Box 68760,

To the Hospital

State Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year)

5 Pending investigation 6 Could not ba determined

28b. Time of

28c. Injury at Work? Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yas 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

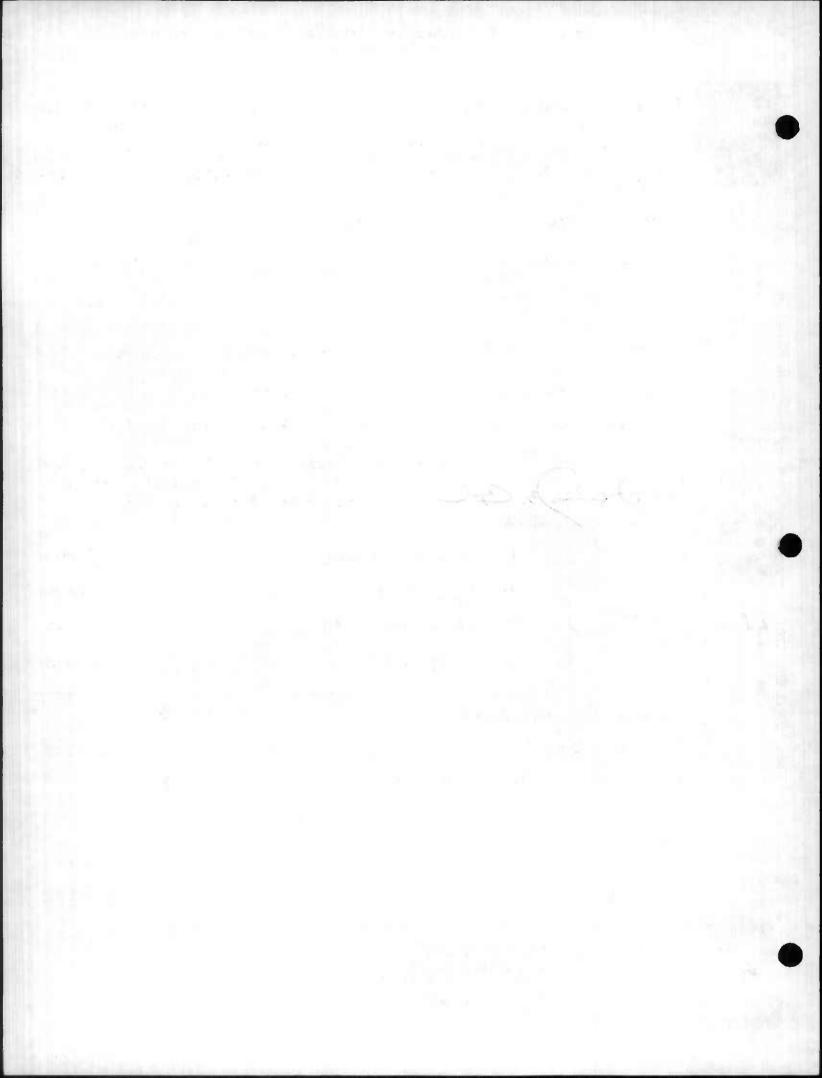
1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and placa, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pCAN UD

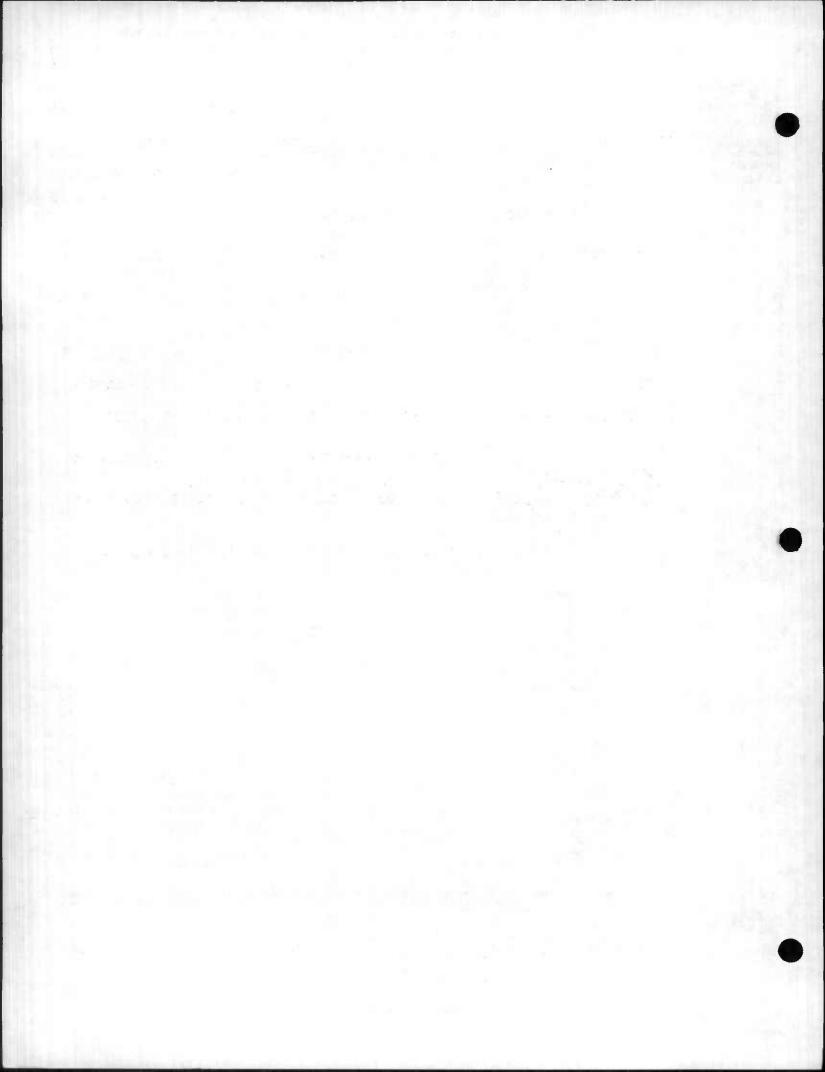
EASTERN AVE.

32. Registrary Signature 31. Date filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 0 1 7 Q 7

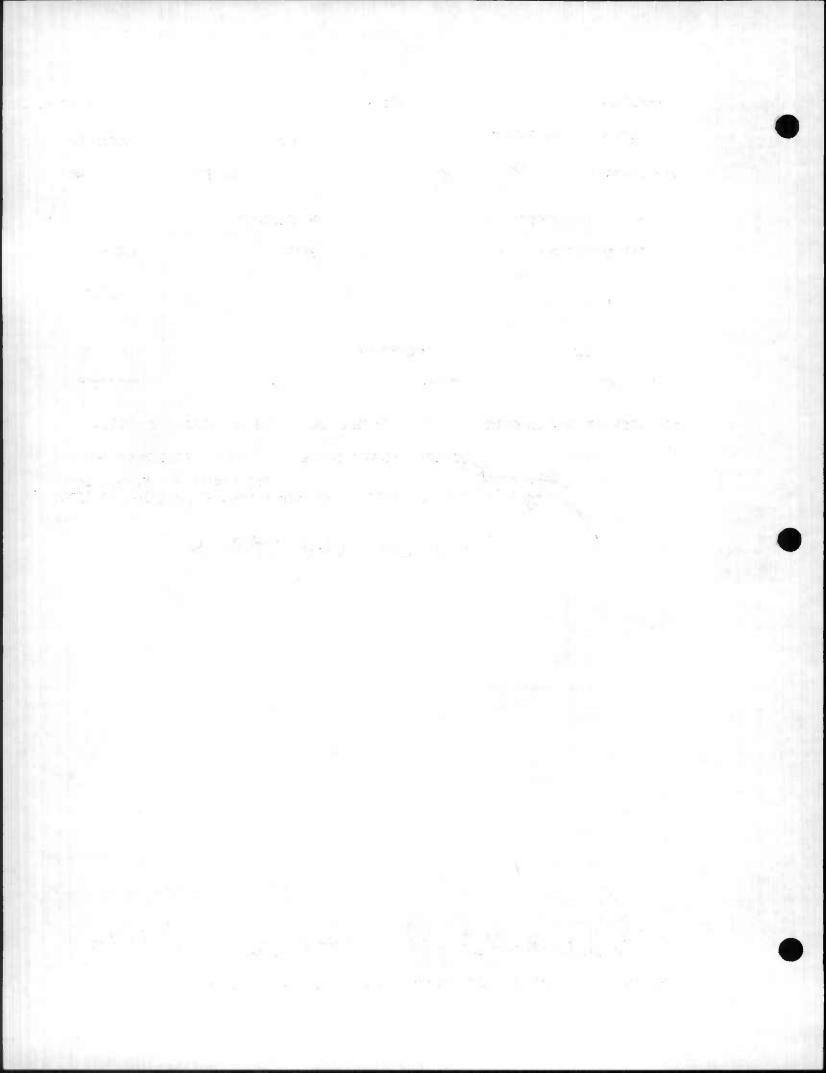
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28a-f show	Director	MD		ALTIMORE			BALT	IMOR	Ε						res 2⊠No
		10e. Street end N	lumber	ΔVF.			10f. Z	10f. Zip Code 21208				10g. Citizen of What Country? USA			
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DHMH 16 Rev 6/95



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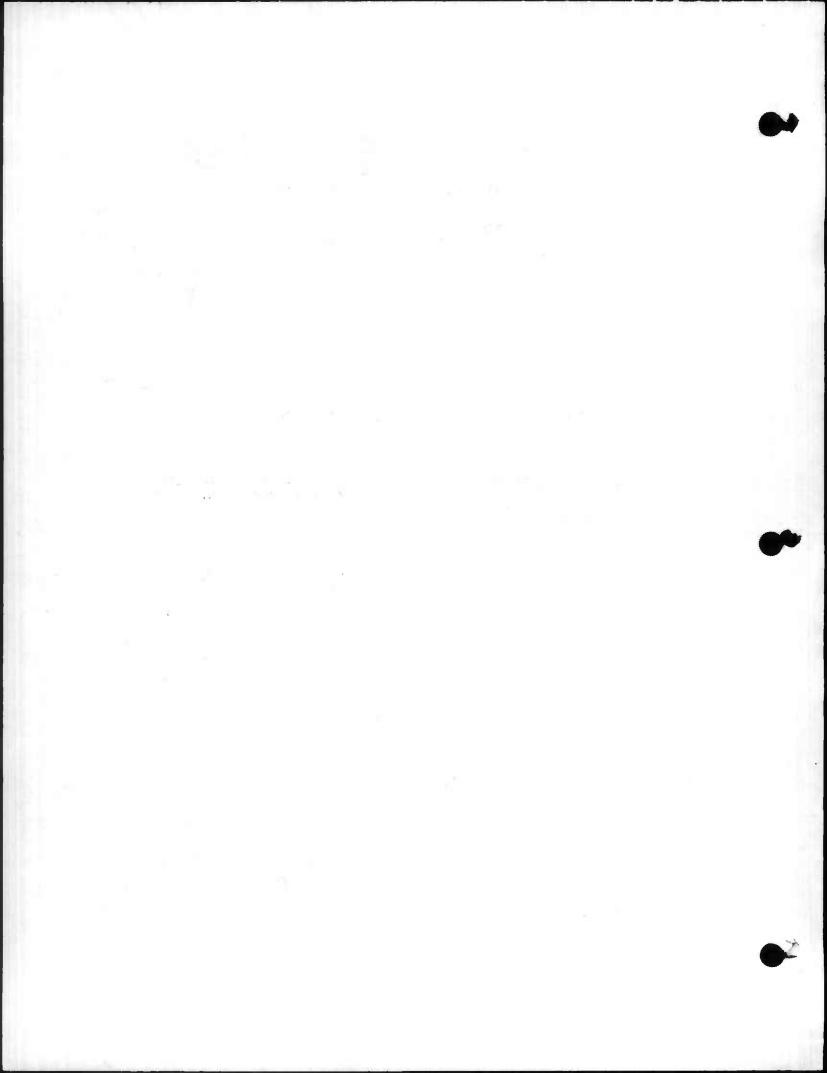
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completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit Page 6 may be þe must examiner hours after death. medical 6 ‡ executed v the attending physician and cor Mental Hygiene prior to bunal, traumatic the death certificate be other 0 injury, signed by the эпу shows been s has be Dept. 23 HOSPITAL OR ATTENDING PHYSICIAN: The law this certificate h Item 9 marked, After t 69 DIRECTOR: after 28 Item . hours TO THE HOSPITAL O
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If Its

2. DATE OF DEATH 3. TIME OF DEATH 22 2:00 DOOM lau. 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In vrs. lest birthday) Month, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 60-PENNSYLVANTA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR GENESIS ELDERCARE - SPA CREEK CENTER ANNAPOLIS ANNE ARUNDEL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MD ANNE ARUNDEL ANNAPOLIS 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 35 MILKSHAKE LANE 21403 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Nover Married 2 Married 1 TES 2 NO Specify: BY Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION early only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 5+ **PHYSICIAN** MEDICINE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) LANDAY PAUL ETHEL FISCHMAN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 ALAN LANDAY (SON) 345 ASPEN CT. MILLERSVILLE, MD 21108 20s. METHOD OF DISPOSITION
1 □ Burlel 2 □ Cremation 3 \$\footnote{1}\text{Removal from State}
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State HAR ZION COLLINGDALE, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory erreat, Approximete ahock, or heert feljure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition neumonia reaulting in desth) DUE TO (OR AS A CONSEQUENCE OF) to Lungs) Renal Cell Caucer hetastatic CERTIFICATION Sequentially ilst conditions, if eny, leeding to immediate TO (OR AS A CONSEQUENCE cause, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Fibrillation PERFORMED? Afrial 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IT UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 4 Homicide determined 29a. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITCH OF, CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 OF DEATH (ITEM 27) (Type, Print) MED 32. REGISTRAR'S SIGNATURE 27 1998 Julia Savidson Randale JAN



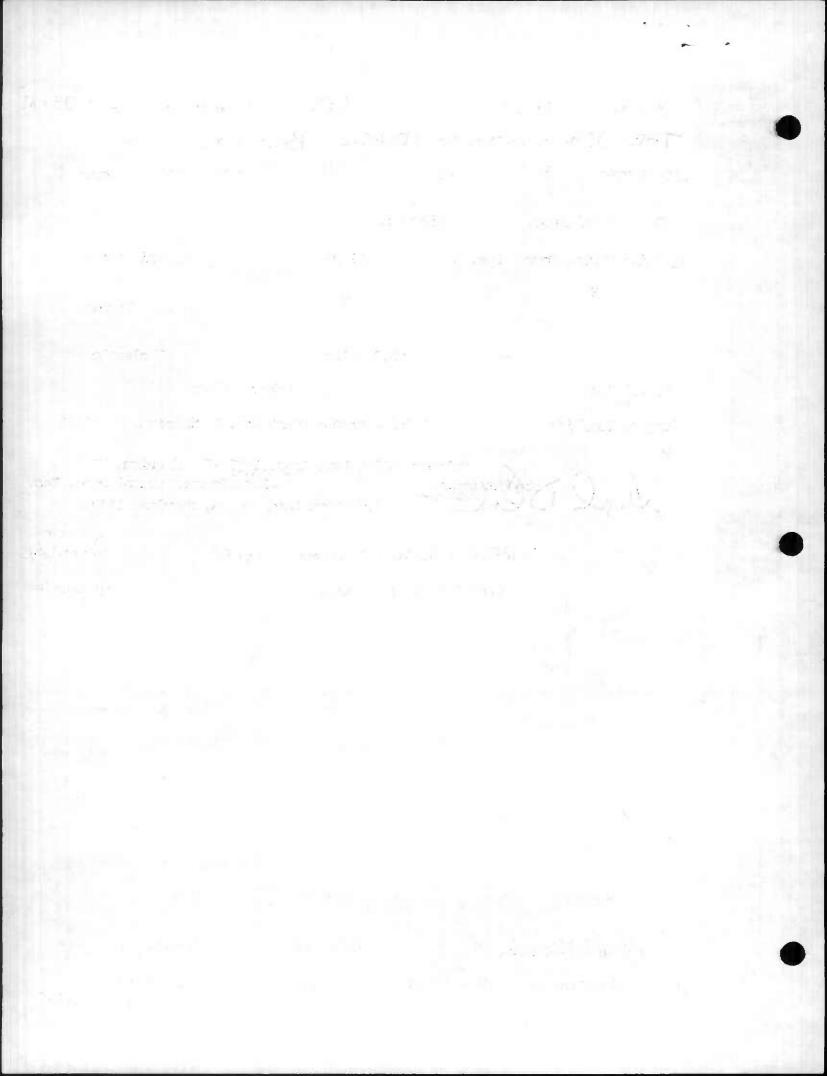


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate d	of Death		Reg. No.) U1	000		
Physiciar		1. Decedent's Neme (First, M	ddle, Las	t)					2. Dete of Do		Yeer	3. Time of Death		
mysiciar Medica/	_	young		HUN			L	EE	JANUAL		1998	3:03 P.N		
Examine	-	4a. Fecility Name (If not institu	tion, give			s Ho	SPITAL	4b. City, Town,	or Location of Dea		nty of Death			
uneral irector		5. Social Security Number 217-41-7790 Usual Residence of Decedent		x M 2□ F		. last birthday, Yrs.	If Under 1 Ye Months De		lrs. 8. Dete of Bi		9. Birthpla	ace (Stete or Foreign ry) Yea		
MOI THE		10e. State 10b. Cou			10c. C	ity, Town or L	ocation				10	d. Inside City Limits		
thed to	Ď.	MD Ba	ltim	ore		Timoni	um					1 ☐ Yes 2√ No		
or 28		10e. Street end Number					10f. Zip Coo	le		10g. Citizan o	t Whet Count	ry?		
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		15. Dece	dent's Edu	ucation			dent's Usual Oc			16b. Kind ot	Business/Indu			
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matic event, t		17. Father's Name (First, Midd	lle, Last)						leme (First, Middle	-				
To F		Ho Kil Lee						Unk	nown Cha	ng				
S THE		19e. Intormant's Name/Relati	onship (T	ype, Print)		19b. Maili	ing Address (Str	reet and Number or	Rurel Route Numb	er, City or Tow	n, Stete, Zip (Code)		
Item 27 is me r other traume		Sung A. Lee/	Wife	31.6				eam Court	Apt. L	Timoniu	m, MD	21093		
		20a. Method of Disposition 1 D Buriel 2 ☐ Crematic	n 3 🗆	Removel from Sta		Plece of Dispo cemetery, cre	osition (Neme of metory or other	f plece)	Dete	20c. Location	n - City or Tow	vn, Stete		
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any injury or once.		21. Signeture of Funerel Sec	Louns	Stephen	1	- 2	2. Name end Ad	Idress of Fecility	Ruck Tow	27-98 Timonium, MD uck Towson Funeral Home, In				
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miner		disease or condition resulting in death)		a. UPPE				TINAL	BLEED			SEVEN DAY		
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00		1 ☐ Yes 2 XNo		Hospital: 1 Kinpe	atient 2	ER/Outpetle	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	Idence 6 🗆 C	ther (Specify))		
		27. Manner of Death 1 Naturel 5 Per 2 Accident	ding stigation	28a. Dete of It	njury De <i>y Yeer)</i>	28b. Time o Injury		njury et Work? 1 □ Yes 2 □ No	28d. Describe	how injury occ	urred			
2 6			ld not be irmined	28e. Placa of building,	Injury - At h etc. <i>(Speci</i>	ome, term, st	reet, fectory, offi	ice	28f. Location City or To	(Street and Nur wn, Stete)	n <i>ber or Rurel</i>	Route Number,		
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Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MOSBY MARIE Month CATHERINE 02.08 am January 4e. Fecility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Good Samaritan Hospital NA Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Hours 1□M 2QF 214-26-5893 65 Yrs. MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits X1 Yes 2 No Baltimore NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 322 East 28th Street 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2/☐No If Yes, Give Year or Dates: 1 Yes 2 No Specify. Specify: Black 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Meridian N/H 11th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Jones Mattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) 322 East 28th Street Baltimore, Maryland Yvette Andrews 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) King Mem. Pk. Cem. 01-28-98 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Onset and Death a. Coronary artery sclerosis

Due to (oras a consequence of):

cardiac arrhythmias Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Pert II. Other elgnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably hypoxia during arrest = encepholopothy 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? endstage renal disease mellitur diabetes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

other than "natural", or items 23a

filed within Hygiene.

12 should be fi h end Mental H 'Is marked ott

permit. Pagas 1 end 2 st Department of Health enc Important: If Item 27 is m any Injury or other traum

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Completed by Physician/Medical Be

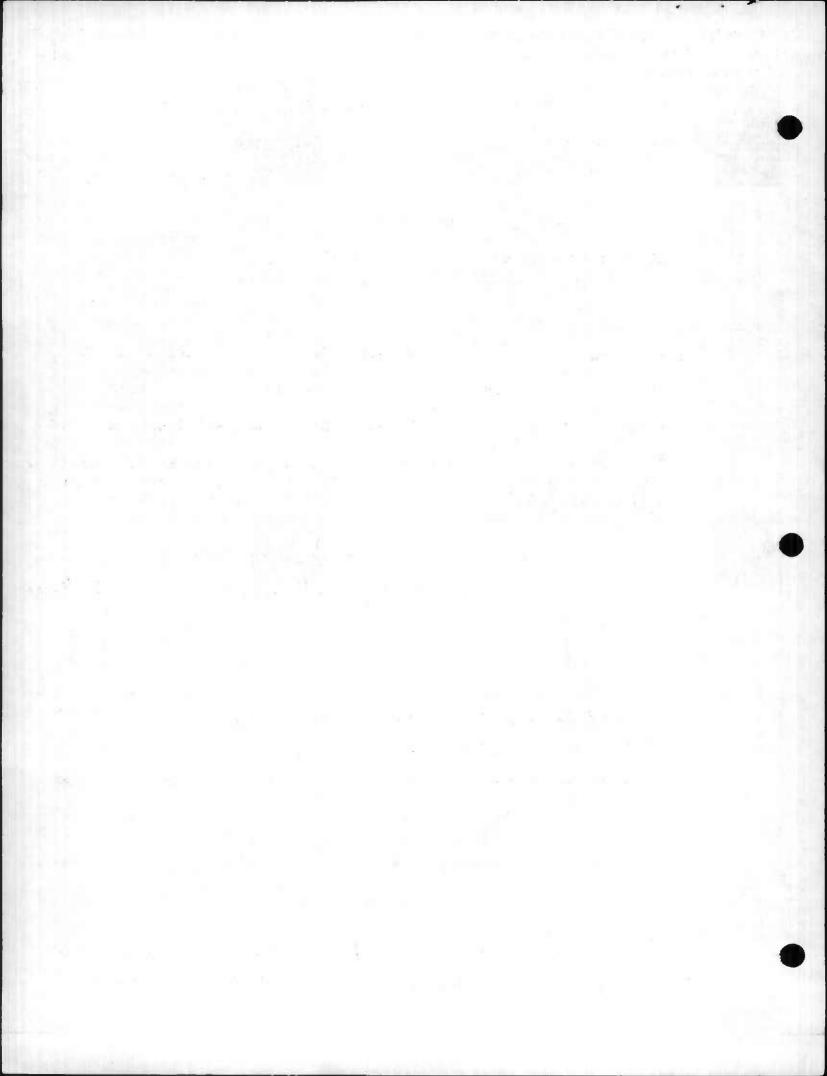
pue attanding physician

• Hospital or Attending Physician: 24 hours efter death. • Funeral Director: After this certifical letaly filled in by the funeral director, I \$

Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Alatural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclen: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. Medicai (Check only one) within 2 29b. Signature end title of certifier 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Good Samariton Hospital, Lock Raven Blod 5601, Baltimore 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 27

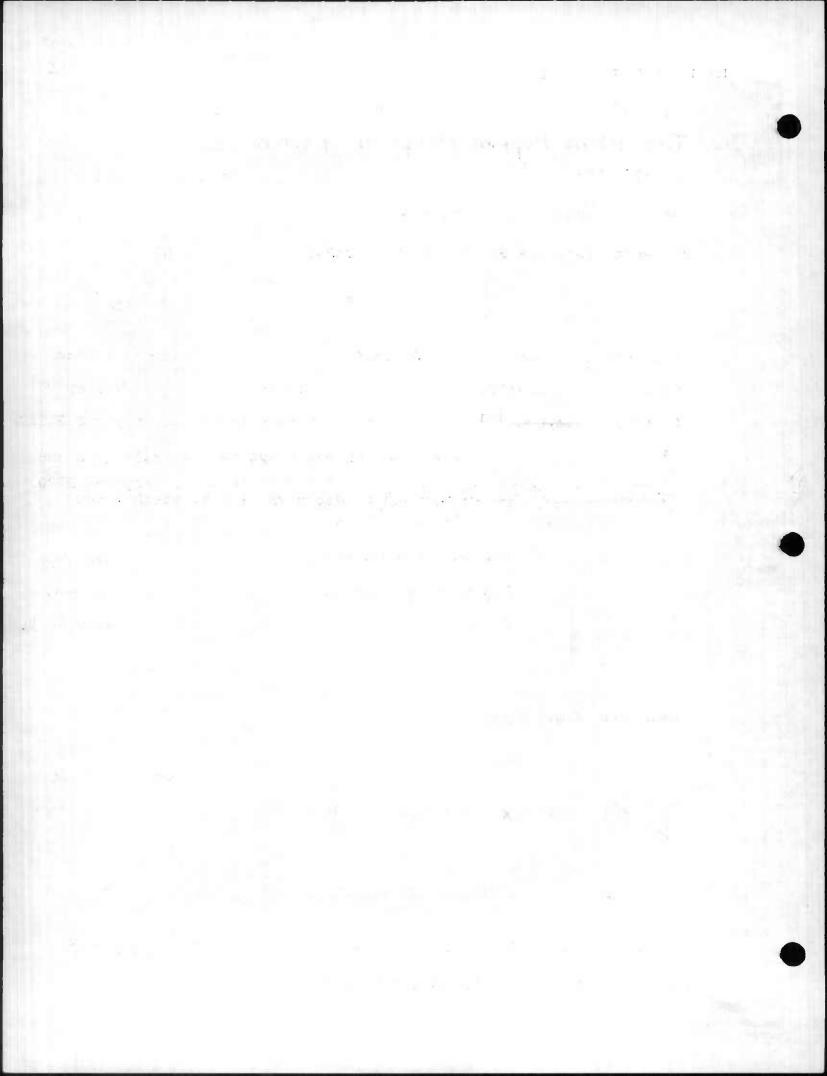
State Registrar



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It	tem#	19a per FH G756 2/3/9		Ce	rtificate	of Death		Reg. No.	0 01002	
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/Medi Exami		4a. Fecility Neme (If not institution, g	ive street end number)	1 1		4b City, Town, or	Location of Deal	1		
		The Johns	Hopkins	Hosp	ital	Dalti	more	N	A	
Funeral Director		5. Social Security Number 6. 217-34-5264 Usuel Residence of Decedent	1 N dCM	(In yrs. last birthday) Yrs.	if Under 1 Months	Year If Under 24 Hrs Deys Hours Min	. (Month, Da	th ly, Yeer) 05-37	Birthplece (State or Foreign Country) NC	
the Maryland 28a-f show	Jo.	10a. State 10b. County Md NA		10c. City, Town or Lo					10d. Inside City Limits XXYes 2 □ No	
death with the Maryland ms 23e or 28e-f show	Funeral Director	10e. Street end Number 910 North Card	oline St.	Apt.#202	10f. Zip C	nde 1205		10g. Citizen of Whet Country?		
₽ 2 8	by Funer	11. Maritel Status 1 □ Never Married 2 □ Married 3 □ XWidowed 4 □ Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	0	Was Deceder If Yes, specify 1 ☐ Yes 25	t of Hispanic Orlgin? (S Cuben, Mexican, Puel No Specify:	Specify Yes or Norto Rican, etc.)	14. Race Blec Specify	e - American Indien, k, White, etc.	
C 4	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 10th Grade		(Give	dent's Usual (kind of work of DO NOT use	done during most of wo retired)	orking		us trades	
d 2 should be filed th and Mentel Hyg 7 is marked othe treumatic event,	BeC	17. Fether's Name (First, Middle, Las			200111		me (First, Middle	, Maiden Sumem		
2 should be filed wi and Mentel Hygien is marked other th reumetic event, me	To	Geno	Neville			Lonni	е		Kearny	
2 short and is ma		19a. Informant's Neme/Reletionship			-	treet end Number or R				
of Heal		Dorothy 20a. Method of Disposition 1 Buriel 2 Cremetion 3	720	20b. Place of Dispo cemetery, cree	sition (Neme metory or other	r place)	Dete	20c. Location -	City or Town, Stete	
bermit. Pages 1 ar Department of Hea mportant: If Item: Iny Injury or other DICE.		4 ☐ Donetion 5 ☐ Other (Spec	ify)			.Cem.01-	29-98	Randa	llstown, Md.	
permit. Page Department Important: If any Injury or		21. Signature of Funeral Service Lice	104	~	M.C.	March FH	1101 E	. Nort	ryland 21202 h Avenue	
Physician /Medical		23e. Pert1. Enter the diseese, or con shock, or heart failure. List on Immediate Ceuse (Final	y one ceuse on eech line				c or respiratory e	rrest,	Approximete Interval Between Onset end Deeth	
Examiner		disease or condition resulting in death)		cardial is		701			one day	
D H	iner			ration pr		in			one day	
ate be executed hysician end the bunal-transit	Examiner	Sequentially list conditions, if env. leeding to immediate	D	ue to (or es e consec						
ificate be execut g physician end as the bunal-trar		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	U,	onitis					three weeks	
as as	n/Medical	resulting in death) Last	d	ue to (or es e conseq	uenca or):					
the death cert y the attendin sched for use.	sicial	Pert il. Other eignificent conditions	contributing to death but	not resulting in the u	nderlying cau	se given in Pert I.	23b. Did	tobacco use cor	ntribute to the cause of deeth?	
that ded b	by Physician/M	End stagE Ren						Yes 2 No	3 □ Probably 4 □ Unknown	
aw requisite been 2 should	Completed b						24e. Wes	en eutopsy ormed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?	
The I	Com						10	Yes 2 No	1 ☐ Yes 2 No	
ifclen: The lav certificete hes rector, page 2	Be	25. Was case referred to medical examiner?	Hamilal V				eth (Check only	one)		
phys this al di	. To	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	Hospital: 1 Inpatient				T	dence 6 Other		
ding th. After	tion	1 Naturel 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	M 200	Injury et Work? 1 Yes 2 No	260. Describe	now injury occurr	9 0	
after dea Director d in by the	Certification:	3 Suicide 6 Could not determined	De Diag of laive	y - At home, ferm, str (Specify)	eet, fectory, o		28f. Location (City or To	Street and Number wn, Stete)	er or Rural Route Number,	
To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funerei Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 12 Certifying P	hysician: To the best of miner: On the basis of e end manner state	exemination and/or in	occurred et l vestigetion, In	he time, dete end place my opinion, death occ	e, end due to the urred et the time,	ceuse(s) and me date end piece, s	nner es steted. and due to the ceuse(s)	
To th To th Comp	Me	29b. Signature end title of certifier			29c. L	icense number		29d. Date signed	(Month, Dey, Year)	
(· mathing	· watter	m.D.	R	ES-000		January	23,1998	
10		30. Name end eddress of person who	completed cause of dea	eth (Item 23e) (Type.	Print)	0 1 1		,		
9		MATTHEW J. WAL			topkin.	s Hospital	-			
Sta Regist		31. Date filed (Month, Dey, Year)	32. Registrer	's Signeture	0					

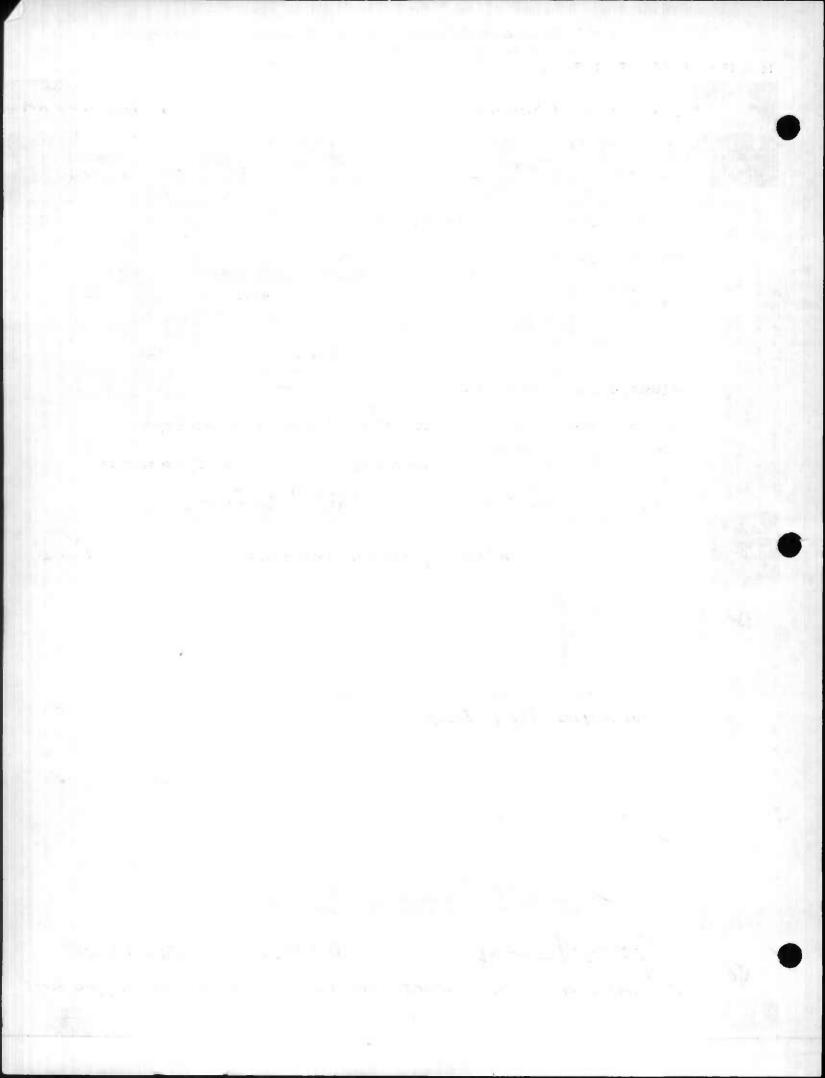
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Item: 17 Per FH Film G-755 1-27-98RC Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** EDITH MAHALIC 11:00 AM JAN 1998 /Medical 4a. Facility Nama (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Chlumbia Howard If Undar 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** Deys 1 M 200 Months Yrs 81 Nov. 14, 1916 Director 162-18 9266 Perrsylvania Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location tem 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 238 3992 Old Columbia Pike 21043 TEA Funeral 12. Wes Dacadant Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indien, Bieck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter a Department of Health end Mental Hygiene. Introcrant: If teem 27 is merked other than "naturel; or iter any injury or other traumetic event. I ☐ Yas 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 white white 1 ☐ Yes X No Specify: Specify à 3 Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) homemaker hone 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be HOWARD PATTERSON buard Tatterson Lo Laura Shirey 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia Nelson - daughter 3992 Old Columbia Pike, Ellicott City Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donetion 5 □ Other (Specify) Westview Cametery Jan. 27, 1998 Avormore, PA 21. Signature of Funeral Service Licansee 22. Nama and Address of Fecility Slack funeral Home, P. A. Ellicott City, Maryland 21043 23a. Part / Enter the disaasa, of complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. 12 MO0535 Approximete intervel Between Onset end Deeth **Physician** immediate Ceuse (Fine) disease or condition resulting in death) /Medical ACUTE MYLOGENOUS LEVILEMIA 1 week Examiner Due to (or as e consequenca of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Dua to (or es a consequença of) Box 68760. Physician/Medical physi Due to (or es a consaguence of) esn Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEART FAILURE (DNGESTIVE Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performad? peen Completed hes certificate 1 ☐ Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: efter death. Director: After this certific Be 25. Was case referred to medical axaminar? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral D Hospital 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted. Medical pletely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signetuge end title of cartifier 29c. License number D 51860 JAN 24, 1998 - MD 10 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3460 ELLICOTT CENTER DRIVE SUITE 103 ELLICOTT CITY AD 21043 JONATHAN FISH MD 32. Registrer's Signature 31. Date filed (Month, Day, Year) State JAN 27 1998

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** BERNICE MERCER JANUARY 98 2:28 PM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore MERCY CENTER MEDICAL Balhmu C 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 3-25-19 Birthplace (State or Foreign Country) **Funeral** 1 M 200 F Months Days Hours Min. 217-34-725 60 Yrs. Director Usuai Rasidanca of Dacadani t0a State 10b. County 10c. City, Town or Location 10d. Insida City Limits **ahow** must be notified at 1 Yas 2 No Director 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 'natural', or thems 23a or 1532 Rosedale 21216 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 IONo If Yas, Giva Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify Black à Specify: 3 ☐ Widowad 4 ☑ Divorcad Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry National Blind Hygiene. Collega (1-4or 5+) Elamantary/Secondary (0-12) 90) grade 17. Fathar's Name (First, Middla, Last) Inspector important of Health and Mental Hy Important if Item 27 is merked other any injury or other traument 18. Mothar's Nama (First, Middla, Maiden Sumama) Workhan loney Geneva Cousar 19a Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Brother 4409 000 Balto M4 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 1-24-98 on 5 Othar (Specify Eunaral Sarvica Licar Jarak 4300 Da / to red ukubash Avenne 2/2/5 far the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximata tntarval Batween Onset and Death Physician /Medical Immediata 1 ausa (Final disaasa or condition resulting in daath) SEPSIS 24 hours **Examiner** Dua to (or as a consequence of). Physician/Medical Examiner Dua to (or as a consequence of): Malignany Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiatad events rasulting in daath) Last The law requires that the death certificate be seed P.O. Box 68760, Dua to (or as a consaquance of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobecco use contribute to the cause of death? 2 □ No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings availabla prior to completion of causa of daath? Be Completed 24a. Was an autopsy certificate 1 Yas 1 Yas 2 No Division of Vital al or Attending Physician: The sefter death.

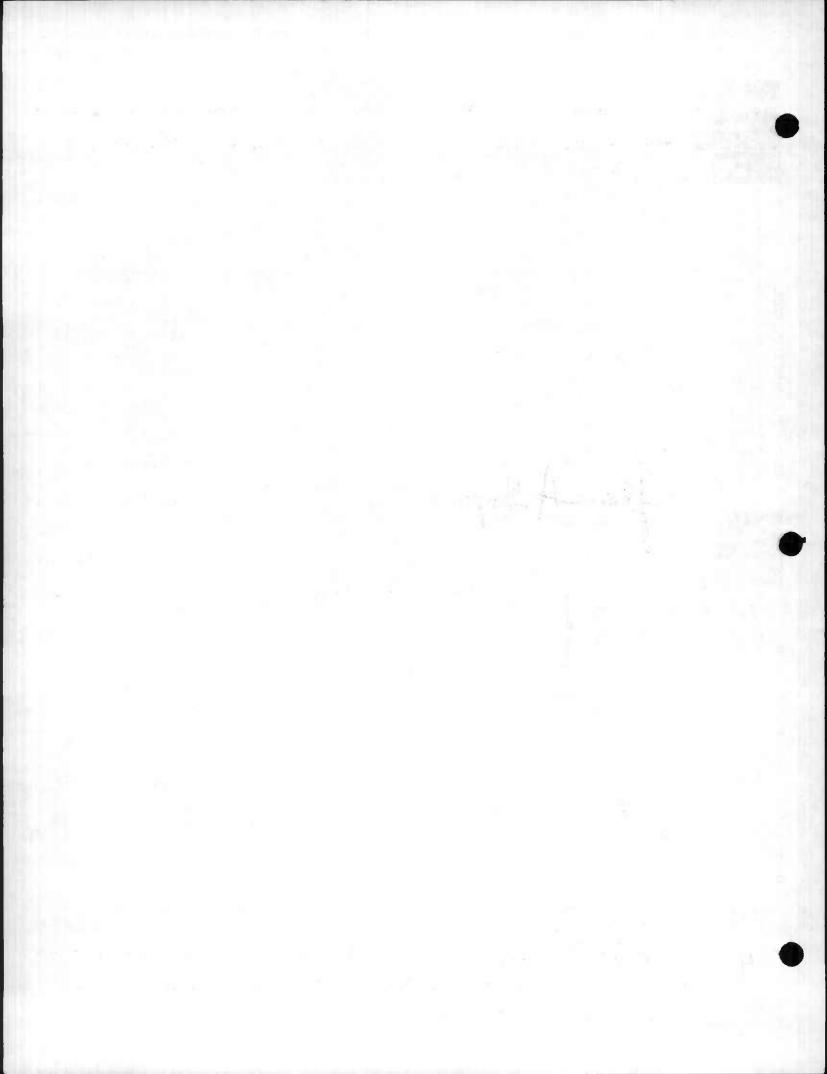
N Director: After this certificate ed in by the funeral director, pe 25. Was casa referred to medical axaminar? 26. Placa of Daath (Check only ona) 1 Yas 2 No Certification: To 1 patiant Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Manner of Death 28b Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 Homlcide • Funeral 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical-Examiner: On the basis of examination and/or invastigation, in my coloring, death occurred at the time, date and place, and due to the within 24 hour To the Funer completely fill Medical 29a. Certifiar (Check only one) xaminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signytur 29c. Licansa number 29d. Data signed (Month, Day, Year) 0218 o completed causa of daath (itam 23a) (Typa, Print) Birnbaum Parl PLACE Baltomore MD 301 JA SON ST M. 32. Ragistrar's Signatura 31. Data filad (Month, Day, Year) State

while Aujason-Randall

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death JAN 1998 George Howard Medicus, Jr. 2Ĭ 6:30 pm 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 F Yrs. 217-22-1932 JUNE 20, 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 🏌 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 906 Frederick Road 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 3 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Flower Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Howard Medicus, Sr. Christine Robarts 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Frances G. Medicus/wife 906 Frederick Rd. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 01/24/98 Eldersburg, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility MacNabb Funeral Home, P.A. George E. MacNabb

301 Frederick Rd. Baltimore, MD 21228

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? likal value replace seest 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? sonticular dice ace. 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident

Division of Vital Records, P.O. Box 68760. The lew requires that the death certificate signed by t this certificate apital or Attending Physician: The hours efter death.

meral Director: After this certificate y filled in by the funeral director, pa

Examiner Physician/Medicai Be Completed by Certification: To To the Hoapital or within 24 hours of To the Funeral D completely filled

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

Completed by Funeral Director

Be

10

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryla Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-1 show any injury or other traumatic event, the Moddail Example must be notified a page.

Physician /Medical

Examiner

3altimore, Maryland 21215-0020

with the Maryland

10

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) State

3 Suicide

29a. Certifier

4 Homicide

31. Dete filed (Month, Dey, Year)

uael

29b. Signature and title of certifier

6 Could not be determined



angone

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.

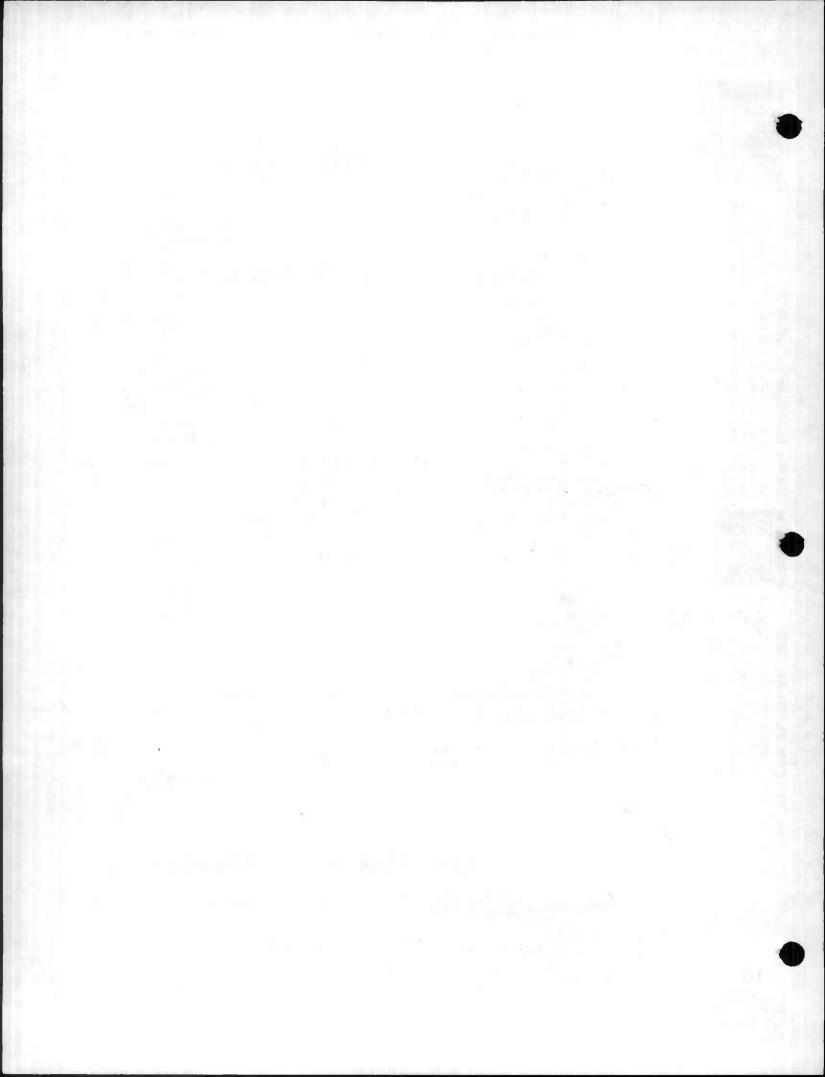
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Michael Schwartz, M.D. 5517-A Ritchie Hgwy. Baltimore, MD 21225

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death PS 1, 1998 **Physician** CHARLES MARSHALL TANUARY 18 hours: 50 VERNON /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner IRVINGTON KNOLLS CARE CENTER BALTIMORE CITY
If Under 1 Year If Under 24 Hrs. 8, Date of F 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1170 M 2□ F Days Yrs. MARYPAND 78 Director 214-12-9951 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE CITY 1 X es 2 □ No MARYLAND N/A Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 S. WOODINGTON ROAD APT. J-4 21229 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade BUS DRIVER ROSEWOOD STATE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SIDNEY MARSHALL SUSIE MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah L. Marshall/Wife 8 S. Woodington Road, Baltimpre Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XXurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. LOUDON PARK 4 ☐ Donation 5 ☐ Other (Specify) 1-26-98 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 21. Signature of Funeral, Service Licenses 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line s that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? decubihis social ulcar 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? mellitis, Stroke 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicel Be 26. Place of Death (Check only one) Hospital: Other: 450 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 25€No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier

Box 68760. Records, P.O. Division of Vital or Attending Physician: death. To the Hospital or Attendition 24 hours after death.
To the Funeral Director: A completely filled in by the fu

signed by t

certificate

After

28a-f show

ò

Items 23a

e filed within 72 hours after al Hygiene.

Pages 1 and 2 should be fill mant of Health and Mental Hant: If Itam 27 is marked oth jury or other traumatic event

Baltimore, Maryland 21215-0020

event, the Medical Examiner must be notified at

10

31. Date tiled (Month, Day, Yeer) JAN 27 1998 Registrar

(Check only one)

K. DANG

29c. License number

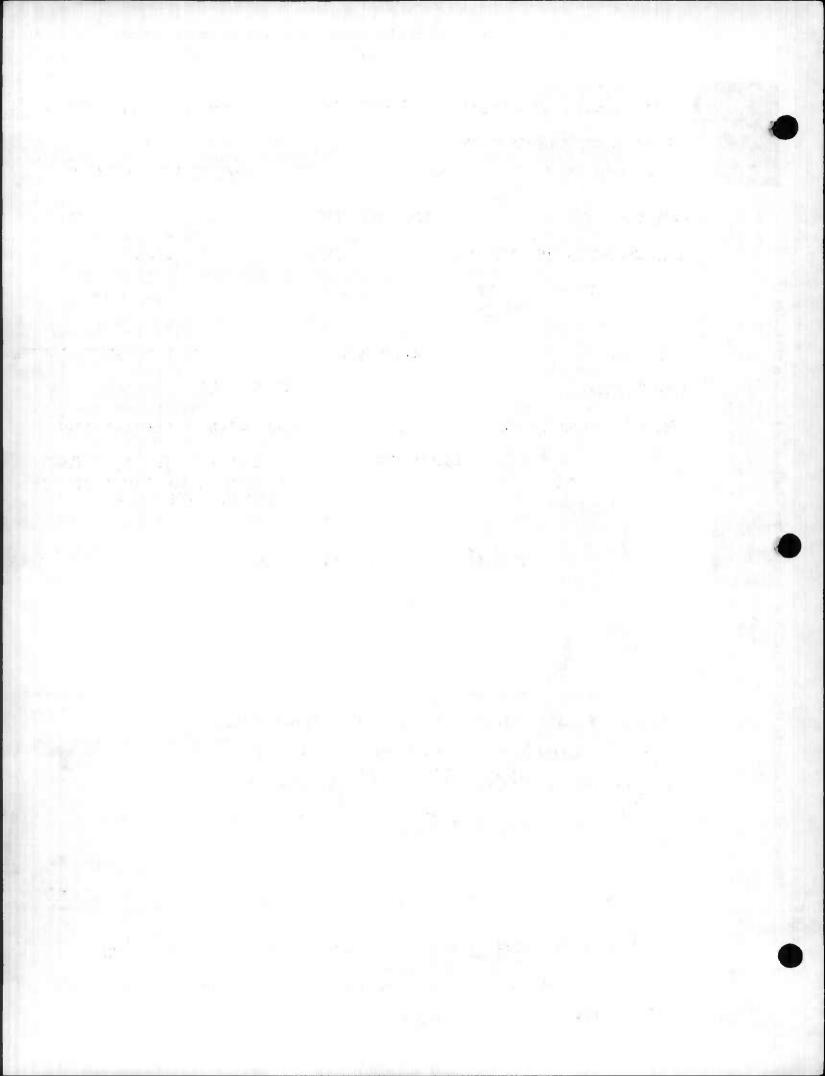
29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Kanal le Paul us

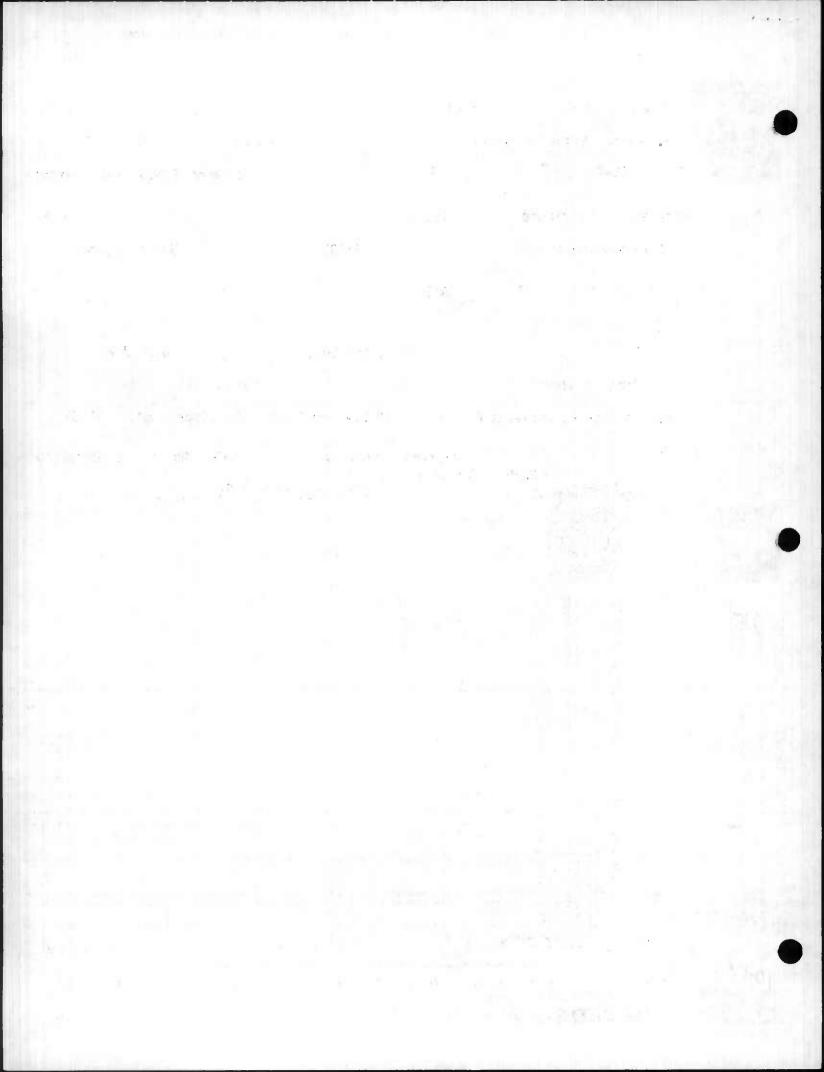
3455 Wilkens Ave. Suite 308. Balto. Md 21229 M.D.

32. Registrer's Signature which Davidson



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State of Maryland / Department of Health and Mental	Hygiene	8	0	8	0	1
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					C	ertificate o	f Death		Re	eg. No.			
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Examiner		4a. Facility Nama (If not institu			1011-10		4b. City, To		cation of Death	4c. County			
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lland	1	10a. State 10b. Cour	ity	1	Oc. City, Town or	Location					10	d. Insida City Limits	
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ifter death with the Me ifters 23e or 28e-f incomment by mortile	la Dic	10e. Street and Number 1512 Weybur	n Road			10f. Zip Code 212			10		Citizen of What Country? United States		
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and 2 sho lealth and m 27 is ma her treum		Mrs. Dorothy		ka/k		ailing Addrass (Stre L512 Weyb				city or Town,		Coda) 21237	
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leath certificate be secuted ettending physician and for usa as the bundariansit claryMedical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Lest	c	Du	a to (or as a cons	sequanca of):							
9 9 9		Part II. Other significant condi	tiona contributing to	death but r	not rasulting in the	underlying causa	givan in Part i		23b. Dld tol	bacco use con	tribute to	the cause of death	
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ysician: The ysician is cartificate director, pag		25. Was casa referred to medic axeminar?	al				26. Place	of Death	(Check only one	1)			
N 0 0		1 Yas 2NNo	Hospital:	Inpatiant	2 ER/Outpet	lent 3 DOA	othar: 4 Nu	rsing Hor	na 5 🗆 Resida	nce 6 Otha	r (Specify)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: "		3 ☐ Suicida 6 ☐ Coul	ing (Mo	a of Injury onth, Day Y		y W	ury at ork? ☐ Yes 2 ☐	No	28d. Dascribe ho	w injury occurre	bed		
s after at Dire ed in b		4 ☐ HomicIda deta	mined 28a. Plac build	ding, atc. (Specify)	July radioly, office			City or Town		. J. Flarer		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert		29a. Cartifiar (Check only one) 1 Certify 2 Madica	ing Physician: To the it Examiner: On the and ma	na best of m basis of ax innar statad	amination and/or	ath occurred at tha Investigation, in my	tima, data an oplnion, dae	d place, e th occurre	and dua to tha ca ad at tha tima, da	usa(s) and mer ta and placa, a	inar as sta nd due to t	ted. he ceusa(s)	
Within Comp		29b. Signetura and title of certif	ar			29c. Lice	nse number		29	d. Date signed	(Month, D	ay, Year)	
		1 Her	Barus	28)		Po	772	7	1,7	Anlina	1176	1000	
וע	3	00. Nema and address of perso	n who complated cau	usa of daat	h (Item 23e) (Typ		, , ,	,	7	TOUTE	7 -6	11993	
041			LWAZE,			JORTH G	REE	JE S	TREET	- 212	201		
State	3	31. Date filed (Month, Day, Yea		Ragistrar's		V-1-111 C	POET		,	12			
Registrar		JAN 27 1		in Day	idson-Rand	482							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg	No.	U	UU
Date of Death	D	Maria	3. Time

29d. Date signed (Month, Dey, Yeer)

January 23, 1998

Physician	
/Medical	
Examiner	

Funeral

Director with the Marylend 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after deeth Hygiene. 12 should be fill h and Mental H Heelth a permit. Papes 1 as Department of Heel Important if hen 27 any injury or

Maryland 21215-0020

Baltimore.

Physician /Medical Examiner

8 hes page 2 director, this

Box 68760 Division of Vital Records. uneral Aftert al or Attenders.

Just after death.

And Director: After the fer To the Hospital within 24 hours a To the Funerai C completely filled

of Death 1. Decedent's Name (First, Middle, Last) January 22, 1998 1115a Mary Tam McCrystle 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 132 S. PATTERSON PARK APT #4 BALTIMORE n/a 8. Date of Birth (Month, Day, Yeer)
Dec. 9, 194 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5 Social Security Number 7. Age (In yrs. lest birthday) 6 Sax Birthplace (State or Foreign Country) 1 M 2 X F 219-42-0398 53 Yrs. 1944 Maryland Usual Residence of Deceden 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No Baltimore City Director Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 S. Patterson Park Avenue 21231 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ■ Never Married 2 ☐ Married 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Apartment 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Frank C. McCrystle Ella S. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. J. Brooke McCrystle (Brother) 1517 Locust Avenue Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corporation 1/24/98 Towson Maryland 21. Signature of Fundan Saluce Licens 22. Name and Address of Fecility KOU Ruck Towson Funeral Home, Inc. 1050 York Road aft. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Alberosclerche lardibruscular disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medicai Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown He Breast þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 2 1XXes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

Chief Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner.

O.C.M.E.

29c. License number

David 31. Date filed (Month, Day, Year)
JAN 27 1998 Registrar

29a. Certifier

(Check only

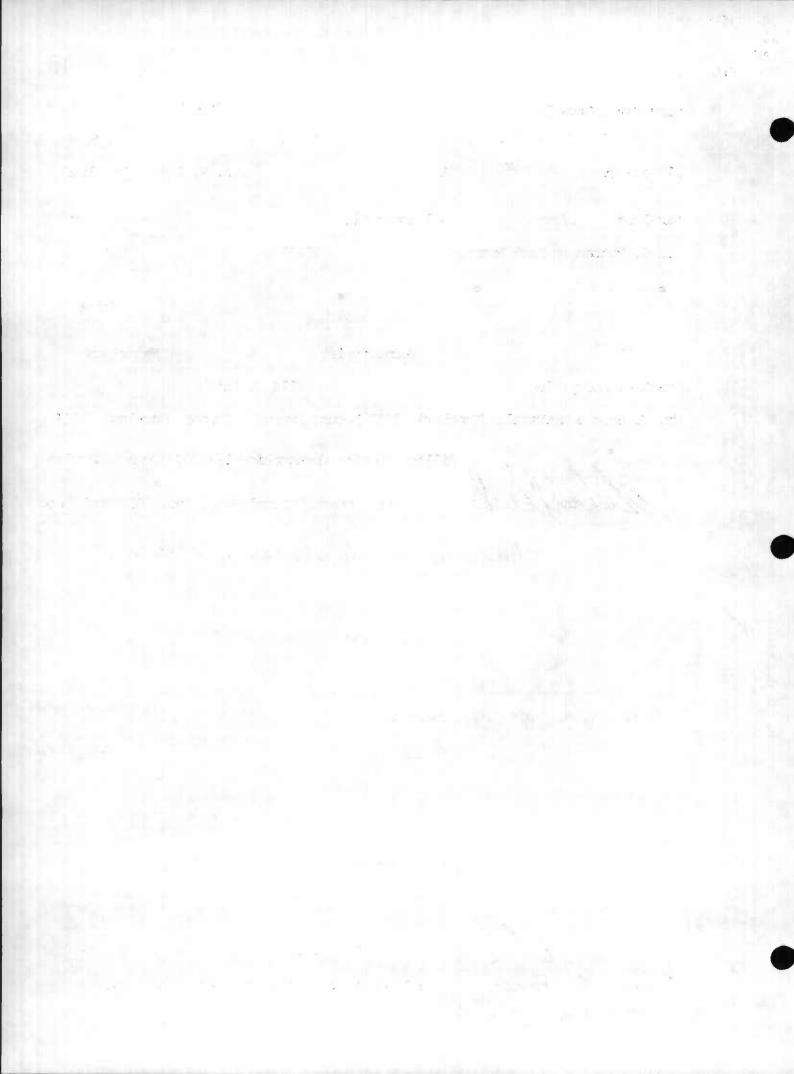
29b. Signature end title of certifier

edical

Fowler 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature

Wildow - Andall

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Frederick E. Nazarenus January 9:00 Am 83 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Elder Care Cator Manor Pa Home City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of jenesis N/A 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) Deys Months 110 M 2□ F Hours 215 10 9319 85 25, 1912 Maryland Usuel Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No N/A Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue 21229 U.S. 12. Was Decedent Ever In U,S. Armed Forces? □X□ Yes 2 □ No If Yes, Give Year or Detes: W • W • I Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: W.W.II White 3X Widowed 4 □ Divorced 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grede completed) 16h, Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 8th Sheet Metal Worker Koppers Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Albert Nazarenus Mary Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Frederick Nazarenus II / son 100 Cedar Hill Road Baltimore, Maryland 21225 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 □ Cremetion 3 □ Removel from Stete 1/27/98 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ranurouski ations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intarvel Between Onset end Deeth Immediate Cause /Final disease or condition resulting in death) to (or as e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consaquance of): Due to (or es e consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Acer evelnibraler 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were eutopsy findings evellable prior to completion of causa of daeth? 24e. Wes en eutopsy performed? DE No 1 ☐ Yes 2 ☐ No 25. Was casa referred to madical examiner? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2No Othar: 41 Nursing Home 5 Residence 6 Othar (Specify) 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Tima of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be datarmined 3 Suicide

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Certification:

Medical

lem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examples must be notified at

Department of Health end Mental Hygiene. Important. If New 27 is marked other than '

Physician /Medical

the Manylend

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rederick Nazarenus

P.O. Box 68760, Division of Vital To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by the

State

Registrar

31. Dete filed (Month, Day, Yaar) JAN 27 1998

- V. CYRIAC. M.D

29b. Signature end title of certifier

4 ☐ Homicide

29a. Cartifiar

8109 RITCHIZ 33 Reciprar's Signature

28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

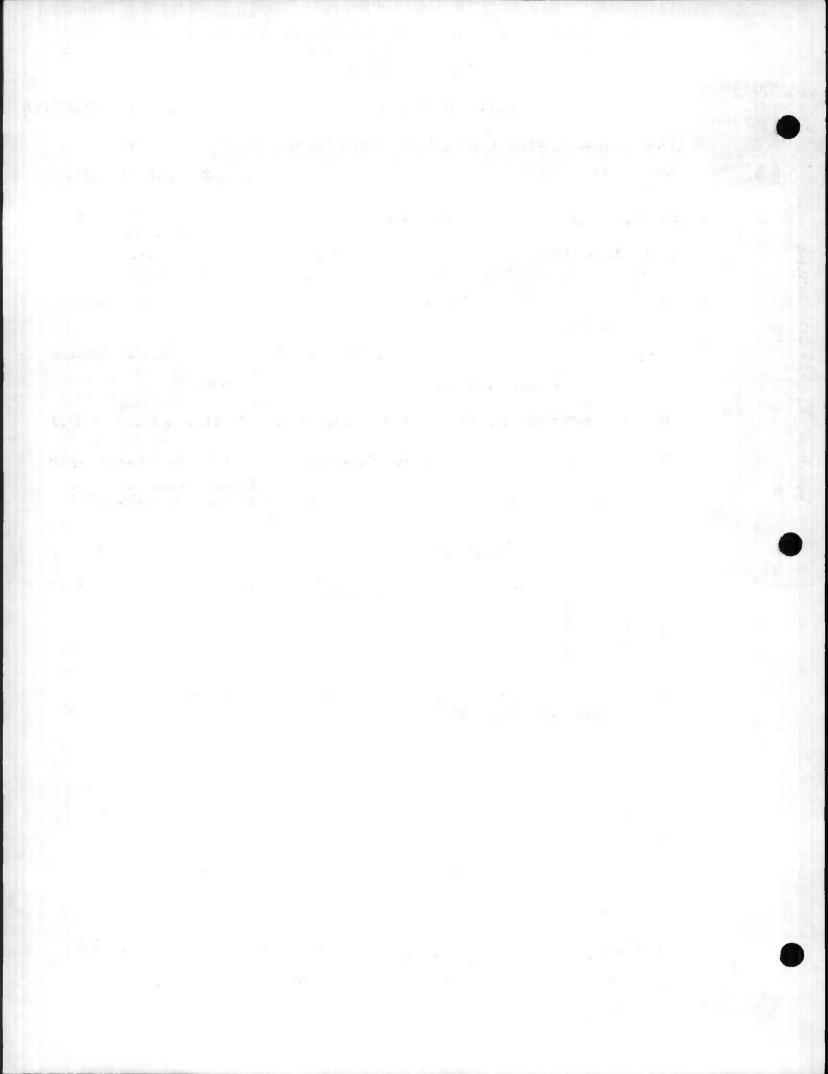
30. Name end addrass of person who complated cause of deeth (Item 23e) (Type, Print) bwy, PASADENA,

102 Certifying Phyelcien: To the best of my knowledga, daath occurred et the time, date end plece, end due to the ceusa(s) end mennar es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end dua to the ceuse(s) end menner steted.

29c. License number

29d. Date signed (Month, Dey, Yeer) 1-23-98

28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day George Sterling Noyes, III 10:40am January 25, 1998 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospice of Gilchrist Towson Maryland N/A If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 028-24-8607 15 M 2□ F 66 July 3, 1931 MA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Clarksville, Maryland Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5607 Foxview Court 21029 United States 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Doto Specify: Specify: White 3 Widowed 4 Opivorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Ship Captain 12th Grade Maritime 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Sterling Noyes, II Esther Ritch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Sterling Noyes, IV / Son 5607 Foxview Court, Clarksville Maryland 21029 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Mathod of Disposition Date tery, cramatory or other placa) Popurial 2 ☐ Cremation 3 ☐ Removat from State Mount Hope Cemetery, January 28, 1998 South Weymouth, MA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Finat CANCEL 10 months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the undarlying ceuse givan in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Onknown 24b. Were autopsy findings eveilable prior to 24a. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hopice 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Expresses must be notified at

Hygiene.

marked other

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permit. Pages 1 end 2: Depertment of Health en Important: If Item 27 is any injury or other trau

Director

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Baltimore, Maryland 21215-0020

the

Examiner

Physician/Medical

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Certification:

edical

1. Natural

2 Accident 3 Suicide

4 ☐ Homicide

29a, Certifier

physician use as attending | been signed by the should be deteched page 2 should certificate hes director. this After deeth.

efter deeth Director: in by 0

Division of Vital Hospital 24 hours To the Hospi within 24 hou To the Funei completely fi

> State Registrar

15 Certifying Physicien: To the bast of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the causa(s) and manner stated. (Check only one) 29b. Signature and title of certifie

JAN 27 1998

5 Pending investigation

6 Could not be

ley ,

29c. License number uno

1 ☐ Yes 2 ☐ No

29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

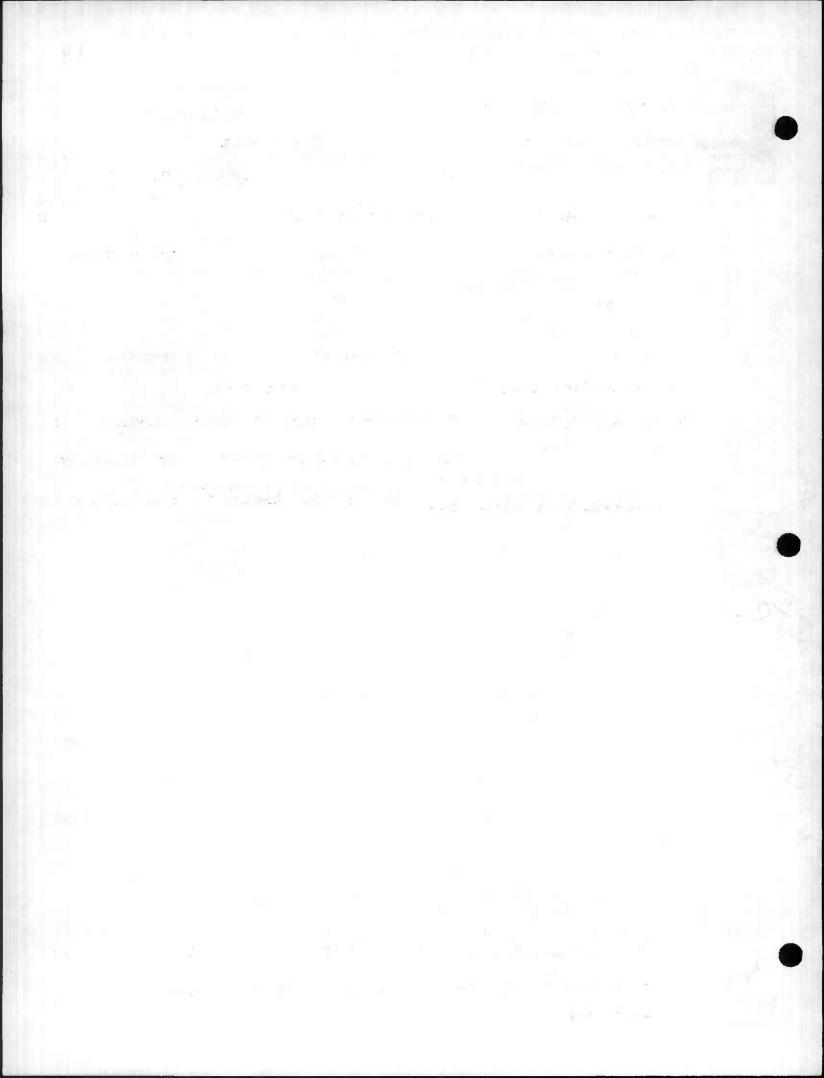
30. Name and addrass of person who completed ceuse el death (Item 23a) (Type, Print)

Anthony Riley, MD 6601 North Charles Street, Baltimore Maryland 21204 31. Date filed (Month, Day, Year)

Injury

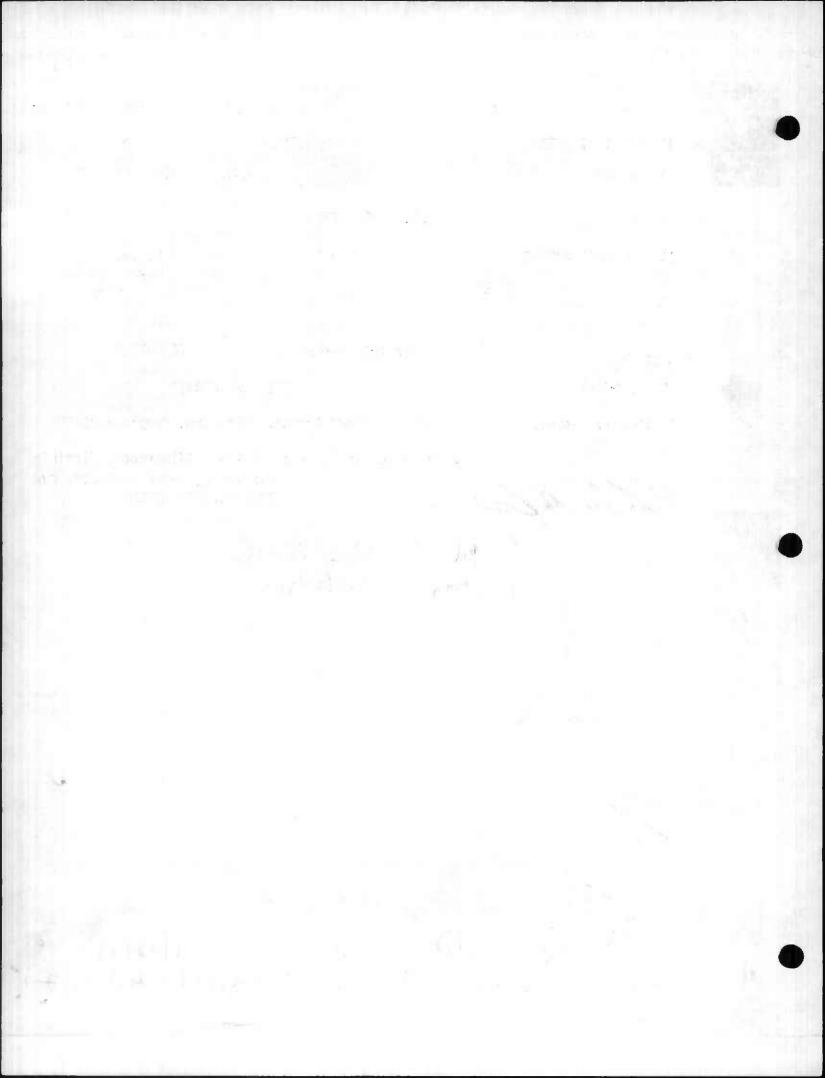
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

37. Registrar's Signature

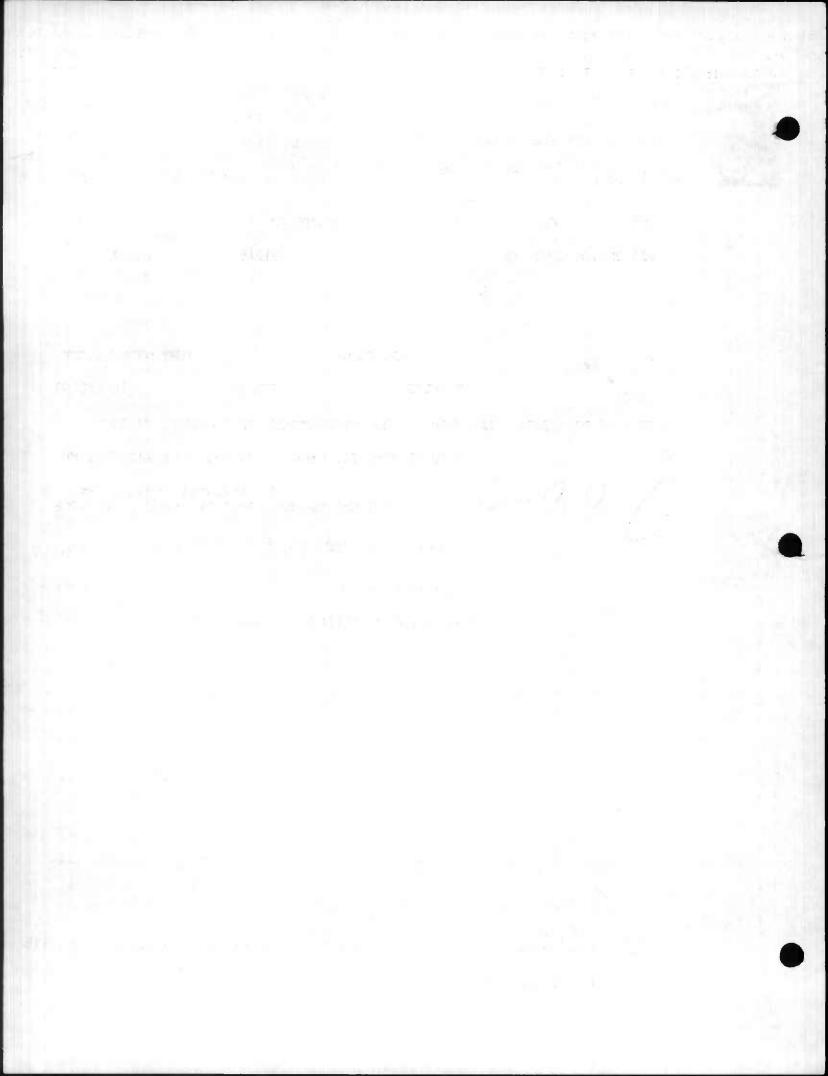


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

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/Medical Examine	_	4e. Fecility Neme (If not institution, g					4b. City, Town,	or Location of Death	4c. County		0120 0111
		INNS OF EVERGRE	EN ·					RE CITY	1	N/A	
unerai rector		5. Sociel Security Number 6. 220-20-9494 Usuel Residence of Decedent	Sex 1□M XXF	7. Age (In yrs. 7	lest birthday) 9 Yrs.	If Under 1 Months		Irs. 8. Dete of Birth (Month, Dev JUN. 25	1918	9. Birthpiec Country VIRGI	OStete or Foreign
WO W		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				10d.	Inside City Limits
28a-f ehow	101	MARYLAND N/A			BALT	IMORE	CITY				1 □X Yes 2 □ No
The must be notified	rai Dire	10e. Street end Number 3809 MILFORD AV	ENUE			10f. Zip C	ode 1207	1	0g. Citizen of U	Whet Country	7
B 2	2	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	2057 2000 2000 2000		Wes Deceder f Yes, specif I □ Yes	nt of HispanIc Origin? Cuban, Mexican, Pu No Specify:			ce - American Indian, ock, White, etc. fy: BLACK	
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Die Ma	D D	Elementary/Secondary (0-12)	College (1-	4or 5+)			retired) Worker		EDUCAT	LION	
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To Re	0	FRANK MORRIS						E LEE MOR		,	
umat	-	19e. Informant's Neme/Relationship	(Type, Print)		19b. Mailin	g Address (Street end Number or	Rurel Route Number	, City or Town,	Stete, Zip Co	de)
r t		Kathleen T. Duaa	way		3809	Milfo	rd Avenue,	Baltimor	e, Mary	/land 2	21207
r oth		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	Bomousl from S	20b. I	Place of Dispo- cemetery, cren	sition (Name netory or oth	of er piece)		20c. Location		
ury		4 □ Donation 5 □ Other (Spec		Ca	lvary 1	Baptis	t Church	1-25-98	Kilmarr	nock, V	irginia
any In		21. Signature of Fitneral Service Lice	1 Pm	sel	-			206 W.NOR	TH AVE		IITY F/H
	1	Pert1. Enter the disease, or col shock, or heert feilure. List only	nplications thet ca	used the deal	th. Do not ente	er the mode	of dying, such es cerc	liac or respiretory err	est,	Int	proximete ervel Between
ian cai	1	Immediate Ceuse (Final	C	Ada				/)		Or	nset end Deeth
iner		disease or condition resulting in deeth)	e	illile	n Ce	race	c Dea	Th			
i d	5		Di	O ve to (or as e conseq	uence of):	With	C		}	
Examiner		Sequentially list conditions	b	Due to (or es e conseq	Hence of).	unin	>		-	
		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events				uooo o.,.					
Physician/Medical	2	Ceuse (Diseese or injury thet initieted events resulting in death) Lest	c	Due to (d	or as a consequ	uence of):					
Medi											
for use	0		d								
y Sic	2	Pert II. Other eignificent conditions	contributing to dea	ath but not res	sulting in the ur	nderlying ceu	se given In Pert I.	23b. Did to	bacco uee co	ntribute to th	e cause of death?
be detached by Physic		Demen	tia					1 □ Y	es 2 10-No	3 Probab	ly 4 Unknow
								24a. Wes e	n eutopsy		eutopsy findings
page 2 should t								perform	ned?	compl of dee	ble prior to letion of ceuse lth?
page 2								1 □ Ye	s 2 No	1 D Y	es 214 No
director, page To Be Co)	25. Wes case referred to medical					26. Plece of I	Death (Check only on	e)		
0		exeminer? 1 Yes 2 No	Hospitel: 1 🗆 In	patient 2	ER/Outpetien	t 3D DOA	Other: 4 Nursing	g Home 5 ☐ Reside	ence 6 Oth	er (Specify)	
funeral	5	27. Manner of Deeth 1 ☐ Natural 5 ☐ Pending	28e. Dete of (Month	Injury , Dey Year)	28b. Time of Injury	280	. Injury et Work?	28d. Deecribe ho	w injury occur	red	
the f		2 Accident investigation 3 Suicide 6 Could not	20			М	1 ☐ Yes 2 ☐ No				
led in by the funer.		4 ☐ Homicide determined	200. Flace C	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, stre fy)	et, factory, o	office	28f. Location (Si City or Town	reet end Numt n, Stete)	oer or Rural R	oute Number,
		29a. Certifier 1 Certifying P	hyelclan; To the b	est of my kno	wledge, deeth	occurred et	the time, date end ple	ace, and due to the co	euse(s) end me	enner es stete	d.
pletely fi		(Check only 2 Medical Exa	miner: On the bas end manne	sis of exemine	etion end/or inv	estigetion, Ir	my opinion, death of	courred et the time, d	ate end plece,	end due to the	e ceuse(s)
E COM		29b. Signature and this of certifier)/	MMT	1	29c. l	Icense number	2	9d. Date eigne	d (Month, De)	, Yeer)
		I VII X	/	1)		125/8		10-	100	/
		1 100	X	1			11110	3	16	LIX	
		30 Name applieddress of person who	completed caryse	of death (Iter	n 23a) (Type, I	Print)	0000	3 14	11	117 -	



hysiciar /Medica Examine		BESSIE N	LASI) ORWITZ						2. Dete of De Month	Dev	Yeer	3. Time of Dee
xamine	al -	4e. Fecility Neme (If not institution in	rive street and numb	ar)				lb. City. Town, or	JANUA Location of Deat		of Death	2:45 f
	r	SINAI HOSPIT	AL, GRE	ans pe	LING A	1E		BALTIM		BALTI		COUNT
ineral rector		5. Sociel Security Number 217–14–3391		Age (In yrs. I 96	est birthday)	If Under Months		If Under 24 Hrs Hours Min	. (Month, De	th ey, Year) 0, 1901	9. Birthp Coun	lece (Stete or For try) MD
show	-	Usuel Residence of Decedent 10e. State 10b. County		10c. City	, Town or Loc	ation	1				1	0d. Inside City Lir
28a-f sh notified	Ö	MD N	/A				BAI	LTIMORE				1∏ Yes 2□
or 28a-f	Director	10e. Street end Number			. 191	10f. Zip				10g. Citizen of V	Vhet Coun	try?
		3929 CLARKS L	ANE #B					21	215			
0,1	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Dete	s? X) No X	if	/as Deced Yes, spec	city Cuba	ispenic Origin? (\$ an, Mexicen, Puer Specify:	Specify Yes or No rto Ricen, etc.)	Blac	e - Americ k, White, WHI	etc.
The Medical	Completed	15. Decedent's (Specify only highest s Elementery/Secondery (0-12)	Education grede completed) College (1-4c	or 5+)	'life. De	ent's Usua ind of wo O NOT us LESLA	ork done i se retired	du <i>rina</i> most of wo	orking	16b. Kind of Bu		
event, p	2	17. Fether's Neme (First, Middle, La	st)		SAL		ADI	18. Mother's Na	me (First, Middle			STORE
metic event, I	0	MORRIS	(Time Print)	PERE			(04		LDIE	Oit T	-	KNOWN)
other traumatic		19a. Informant's Name/Reletionship GERTRUDE SCHN		AUGHTE				AVENUE	Rural Route Numb	FIELD, P		
other	-	20e. Method of Disposition		20b. P	lece of Dispos	ition (Nar	me of		Date	20c. Location -		
5 =		Donetion 5 Other (See	☐Removel from Ste	TO	emetery, crema H EL ME				1/25/98	RANDAL	LSTOW	N, MD
any Injury	Donetion 5 Other (Specify) 21. Singeture of Funeral Service Licenses 22. Name end Address of Fecility 23. Name end Address of Fecility 24. Name end Address of Fecility 25. Name end Address of Fecility											
	-	23a Furth Enter the disease, or co	mplications that cour	the death	Bo not ente	900 F	Reis	terstown	Road Pi	kesvill	e, MD	
ician		23a fant Enter the disease, or co	ly one ceuse on eecl									Approximate Intervel Between Onset end Death
dical niner		Immediate Ceuse (Final disease or condition	A	CON	GEST	IVE	HE	ARTF	FAILUR	£		10 DAY
	ner	resulting in death)			es e consequ							10 DAYS
buriel-transit		Sequentielly list conditions,	D	b. HYPONATREMIA Due to (or es e consequence of):								1- NAV
Ž 7		Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury	C	Pul	MONAL	-4 1	HMP	ENTENSI	DN			10 DAY.
s the	3	thet initieted events resulting In death) Lest		Due to (or	es e consequ	enca of):						
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should									24a. Wes	en eutopsy ormed?	eve	ore eutopsy findin alleble prior to appletion of ceuse deeth?
Page 2	E								10	Yes 2 No	1 [Yes 25 No
director, p		25. Wes cese referred to medical examiner?						26. Plece of De	eth (Check only	one)		*
al dire	2	1 ☐ Yes 2 ☑ No	Hospital:		ER/Outpatient	3□ DC		4 Li Nursing	Home 5 ☐ Resi	idence 6 □Oth	er (Specify	1)
ie c	ation:	27. Manner of Deeth 1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigat					28c. Injur Wor 1 □	y et k? Yes 2 □ No	28d. Describe	how injury occur	red	
led in by the funera		3 Suicide 6 Could not determine	28e. Plece of building,	Injury - At ho etc. (Specify	me, farm, stre	et, fectory	y, office		28f. Location (City or To	Street and Numb wn, State)	er or Rure	l Route Number,
completely filled in by the fu		29a. Certifier 1 Certifying (Check only one) 1 Certifying (1	Phyelclan: To the be aminer: On the besis end menner	of examinat	vledge, death ion end/or Inve	occurred estigetion,	et the tin	ne, dete end plec pinlon, deeth occ	e, end due to the urred et the time,	ceuse(s) end me date end plece,	nner es si end due to	eted. the cause(s)
Id M		29b. Signeture end title of cartifier	00			290	c. Licens	e number		29d. Date signe	d (Month,	Dey, Year)
0		> D Tend	lles						321 DT9020		LAR'	1 22,19
		30. Name end eddress of person wh	o completed cause of	of deeth (Item	23e) (Type, P	Print)	ITA	(GRES	ENSPRIN	FAVE.		



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Dey Year **Physician** NADOLNY 23, 1998 5:25 AM Carville January /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give streat and number) 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore If Undar 1 Year 8. Data of Birth (Month, Day, Year) July 20, 1920 9. Birthpiaca (Stata or Foraign Country) Mary land 5. Social Sacurity Number 6 Sex 7. Aga (In yrs. last birthday) **Funeral** 1₩ 2□F Months Days Hours Min 77 Vrs 214-16-8287 Director Usual Rasidance of Dacedant with the Merylend r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore Md. Essex 1 Tyes 2 KINO Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? d 2 should be filed within 72 hours after death with I and Mental Hygiene.
7 is marked other than "natural", or itema 23a or it transmitted other than "natural", or itema 23a or it transmitted. 21221 USA 529 Back River Neck Road Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian. Biack, Whita, atc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: White þ 3 Ø Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Tool & Dye Maker MArtin's 8th 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Irene Joseph Nadolny 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Pages 1 end 2 si ment of Health end lant: if item 27 is r jury or other traur 933 Foxwood Lane Baltimore Md. 21221 Carville Nadolny Jr./son Baltimore, 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Page Depertment of Important: If any injury or once. 4 Donation 5 Othar (Spacify) St.StanislausCemetery 1/26/98 Baltimore Md. 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility Connelly Funeral Home of Essex les 300 Mace Ave. Baltimore Md. star tha mode of dying, such as cardiac or respiratory arrast, onne 23a. Pert1 Enter the disease, or complications that caused the death. Do shock, or haert feilura. List only one cause on each line. Approximeta Intarval Batween Onsat end Deeth **Physician** /Medical Immediate Ceuse (Final 9 Days disease or condition rasuiting in death) a Left Subdural Hematoma Examiner Due to (or as a consequance of): Examiner b Intracerebral Basal Ganglia Hemorrhage Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disaasa or Injury that initieted avents rasulting in death) Last Dua to (or as a consaquance of): Hypertensive Atherosclerosis Physician/Medical Division of Vital Records, P.O. Box 6876 Dua to (or as a consequance of): 98 esu. signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Prostatic Cancer þ 24b. Ware eutopsy findings evelleble prior to complation of ceusa of daeth? 24a. Was an eutopsy Completed certificate hes b 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical examiner?
10 Yas 2□ No
27. Mannar of Death Physician: director, Be 26. Placa of Death (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Attending 1 Netural 5 Panding or Attendinefter death. 1 ☐ Yas 2 No Investigation Jan. 14, 1998 11:00 a M 1 D Fell on cement in backyard 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete) 529 Back River à 4 Homicide 24 hours efter Funeral Dire letely filled in b Backyard of home Neck Rd., Balto. Md. 21221 Hospital Backy at the final basis of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner a stated.

20 Medical Examinary On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

10 Defend the final fina 29a. Certifier Medical

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

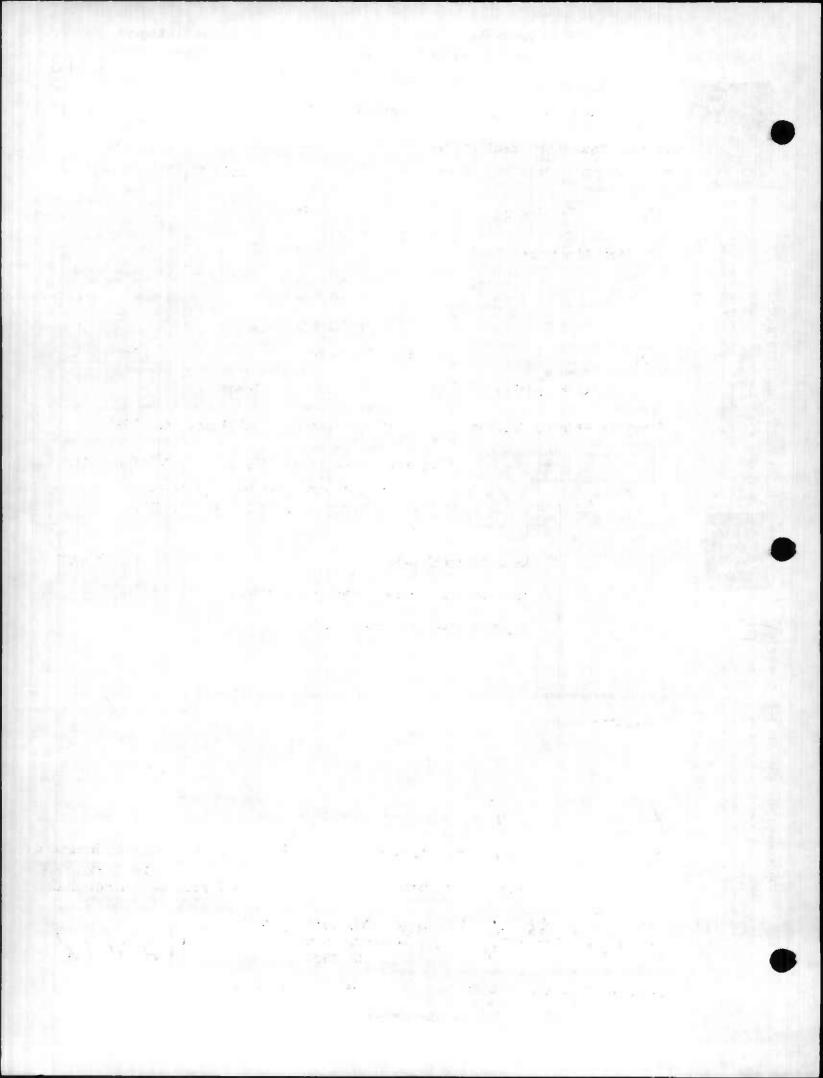
29b. Signatura and titla of certifiar

JAN 27 1998

404 Eastern Blvd. Balto, Md. 21221 Jahangir Khan MD. 31. Data filed (Month, Day, Year)

State Registrar D#22503

To the I within 2 To the I complet



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death K. OPPENHEIM Month **Physician** VIOLA 1998 7:36 AM January 21 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A Hours Min. 8. Date of Birth (Month, Day, Yaar) MAR . 29, 1917 If Undar 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M XXF Months Days Yrs. 215-07-9820 80 Director Usuel Rasidance of Decedant the Maryland 10a. Stete 10b. County Items 23a or 28a-f show iner must be notified at 10c. City. Town or Location 10d. Insida City Limits N/A BALTIMORE Director MD XX Yas 2 No 10e. Sfreef end Number 10g. Citizen of What Country? 10f. Zip Code 2500 W. BELVEDERE AVE. U.S.A. #1017 21215 death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ሺ No if Yas, Giva Yaar or Datas: 11 Maritel Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. traumatic event, the Medical Examiner filed within 72 hours efter 1 Navar Marriad 2 Married Maryland 21215-0020 ò 1 ☐ Yas 2 ☒ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural". 15. Decedant's Education Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highast al Hygiana. Elementary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic event Be SAMUEL KLITZNER SEIDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BENJAMIN OPPENHEIM / HUSBAND 2500 W. BELVEDERE AVE. #1017 BALTIMORE, MD 21215 Baltimore. 20a. Mathod of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, Steta 3 □Ramoval from State 1X Burial 2 Crema permit. Page Department of Important: If any injury or once. KOVNA CONGREGATION 1/23/98 ROSEDALE, MD 4 Donation 5 Dothar (Spacify) 21. Signature of Sineral Service Six 22. Nama and Addrass of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 cations that cousad the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ly ona causa on each lir **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical Myocardial 6 Weeks Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Ceusa (Disaase or injury that initiated avants rasulting in daeth) Last use as the buriel-tren Dua to (or as e consequance of): Box 68760, attending physician Due to (or es a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à Completed 24a. Was an eutopsy 24b. Wara autopsy findings performed? eveilable prior to completion of cause of deeth? After this certificate hes 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: director, Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only one) 1 ☐ Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatienf 3 DOA uneral 27. Manner of Death 28c. Injury et Work? 28d. Dascribe how injury occurred s after dea. 1 Natural 2 Accidant 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 ☐ Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ThomicIda 0 To the Hospital of within 24 hours aft To the Funeral Di completely filled in Medical 16 Certifying Physician: To the best of my knowledge, daeth occurred at tha time, date end plece, end due to the causa(s) and mannar as stated.
2 Madical Examiner: On the best of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the causa(s) 29a. Cartifier (Check only one) end mannar steted. 29b. Signature and titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) AS 2402321 RN9492 January 21, 1998

State Registrar 31. Date filed (Month, Pay, Year) JAN 2 7 1998

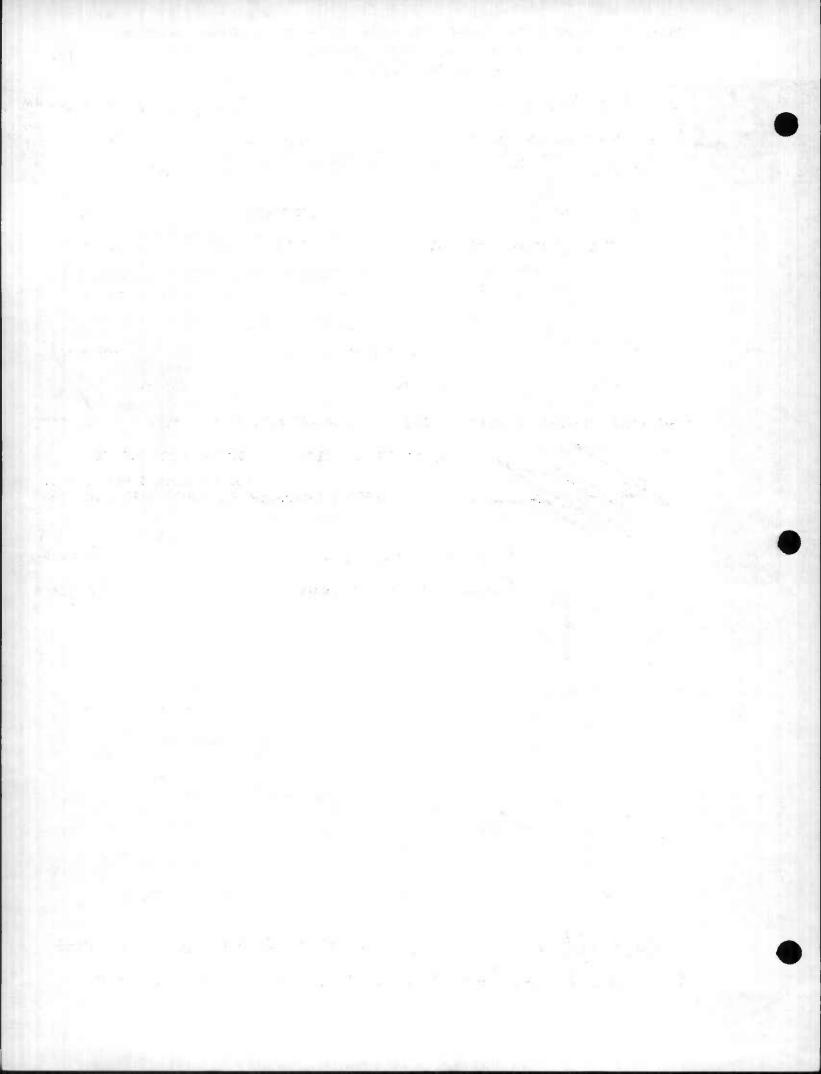
Nekrich

Robert

30. Nama and eddress of person who complated causa of death (Item 23a) (Type, Print)

2401 West Belvedere Avenue 32. Registrar's Signatura Julia Davidson Rendale Baltimore, Maryland 21215

V



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 26, 1998 Yeer **Physician** JAN. WILLIE J. PARKER 8:35AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2780 THE ALAMEDA BALTIMORE N/A Hours Min. 8. Dete of Birth (Month, Day Year) APR - 7,1938 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) 9. Birthpleca (State or Foreign **Funeral** Months 1₽M 2□F Deys 250-56-3947 59 Yrs Director SOUTH CARIKUBA Usuel Residence of Decedent the Marylend 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothing at MARYLAND N/A BALTIMORE CITY 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2780 THE ALAMEDA 21218 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritei Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. of filed within 72 hours after I Hygiene. IN TYPES 2 NAR. 16, 1961 YES 2 NO MAR. 16, 1963 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 Specify: NEGRO à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) INDEPENDANT CAN CO. Elementery/Secondary (0-12) College (1-4or 5+) 12TH FLITTER OPERATOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 12 should be fine and Mentel H UNKNOWN ESTELLE PARKER Lo 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pemit. Pages 1 and 2 sh Department of Health end Important: If item 27 ie m any Injury or other treum once. CHARLENE PHYALL/daughter DEBORAH PHYALL /DAUGHTER 20b. Plece of Disposition (Name of cametery, cremetory or other place)

20b. Place of Disposition (Name of JAN. 30, 1998 Co. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State GARRISON FOREST VETERAN CEM. OWINGS MILLS MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 23a. Pert1. Enter the disease, or complications that cause of shock, or heart feilure. List only one cause on each line. to not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC CANCER MONTHS Examiner Due to (or es a consequence of): Examiner CANCER OF THE LARY WX 4EARS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown signed t 7, teriocclustic Heart D Records. by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings Completed evaileble prior to completion of cause of deeth? certificate has page 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: After t Division Attending 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: the 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 4 Homicide Hospital 24 hours e Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) within 2 29b. Signeture end title of certifier 29c, License number 29d. Dete signed (Month, Dev. Year) MO GA 13664

, 1576 MEREITT BWD

21722

BALTO, MD

State Registrar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

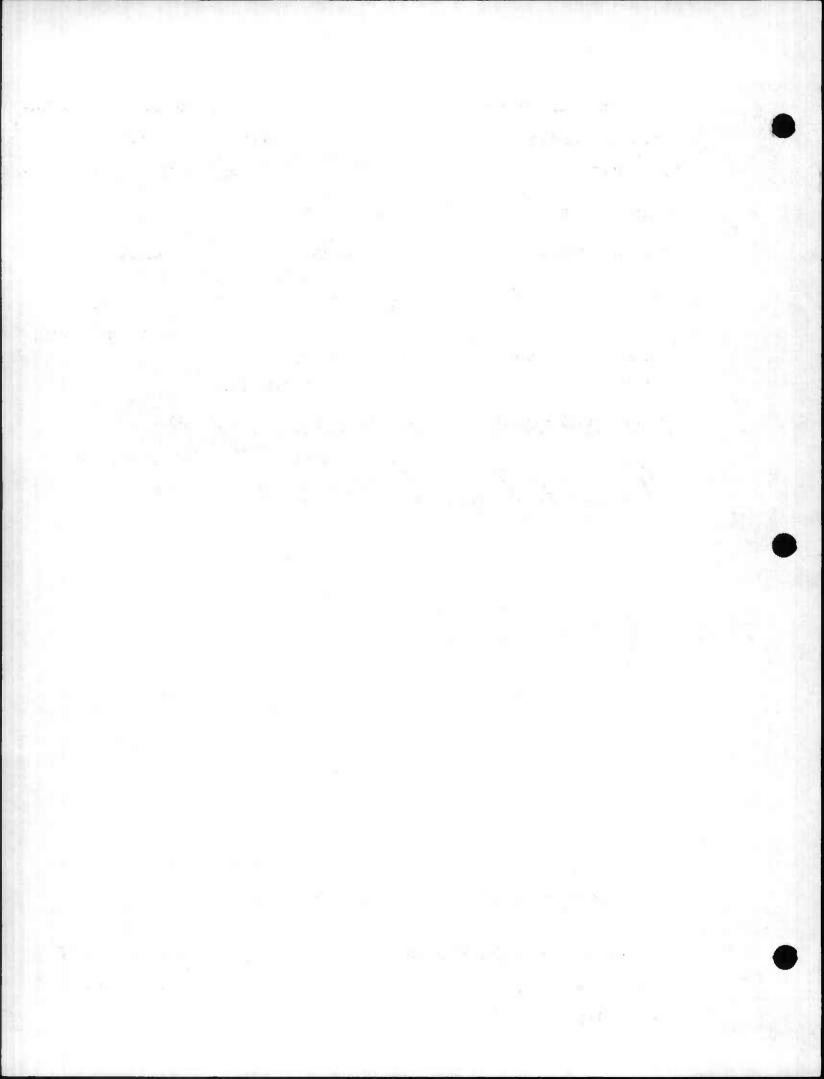
32 Flug strer's Signature

B. C VENERACION JR MORA

31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

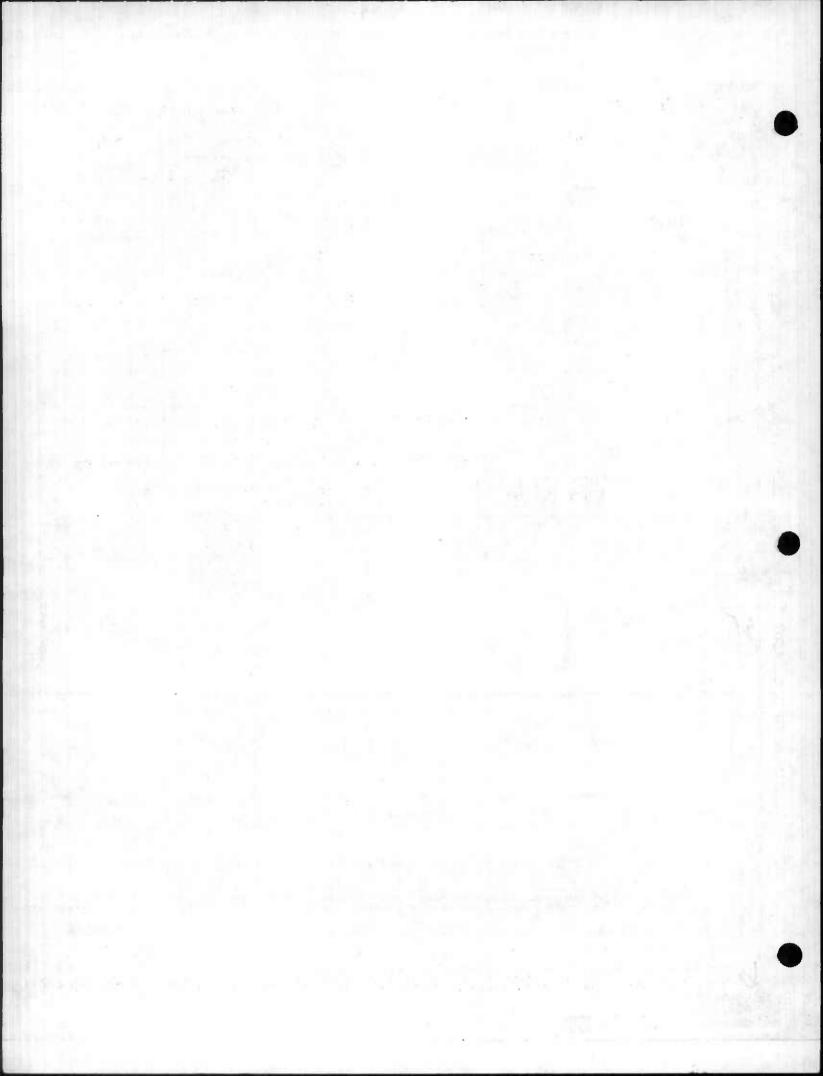
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State of Maryland / Department of Health and Mental Hygiene o

						tificate		Death		Reg. No.	UI	810
Physic /Medi		1. Decedant's Nama (First, Middla, La ALBERT		01701	24	41			2. Data of De Month TANNAK	Day	1998	3. Tima of Dea
Exami		4a. Fecility Nama (If not institution, gi Keswick Mult			r		4b	City, Town, or t Balti		4c. Coun	ty of Death	/ A
Funeral Director			Sax 1□XM 2□ F	7. Aga (In yrs	s. last birthday) Yrs.	If Under 1 Months [Year Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da OCT 2	th (Year) 1902		lace (Stata or For try) ngary
ylend		10a. Stata 10b. County		10c. C	City, Town or Lo	cation					1	0d. Insida City Lin
th with the Maryler 23a or 28a-f show	octor	Maryland N/A			В	altim	ore					1 XYas 2□
with ti	Dir	10e. Straat and Number 700 W. 40th S	troot			10f. Zip Co		211		10g. Citizan of		try?
Items Interm	y Funeral Director	11. Manital Stetus 1 Navar Married 2 Marriad	12. Was De Armed F	2X No		Was Decedan f Yes, specify	t of His Cuban	panic Origin? (Sp , Maxicen, Puarto	pecify Yas or No Ricen, etc.)		ace - Amaric ack, Whita,	
72 hours "neture!",	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedant's E	Year or	Dates:		lant's Usual C				Spec	Wh	ite
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d 2 should be filed th end Mental Hygi 7 is merked other traumatic event,	Be	17. Fathar's Name (First, Middla, Last			•			18. Mother's Nam		Maidan Suma	me)	adout
should be filed nd Mental Hygi marked other imatic event,	10	Mark Pomor								eth Bakos a Number, City or Town, State, Zip Coda)		
d 2 should be sh		19a. Informant's Name/Ralationship (Elizabeth P. Ca	arpent	er/dau	ghter			oln Aven				
emit. Peges 1 end 2 should be filed wir separment of Haalih end Mental Hygien mportant: if item 27 is merked other tha ny injury or other traumatic event, the		20a. Mathod of Disposition 1 Burial 2 Cramation 3 C 4 Donation 5 Other (Specia	Removai from	20b.	Place of Disposementary, cran	sition (Nama natory or othe	of ar placa,	,	Data 1/24/98	20c. Location	- City or To	
permit. Peg Dapartment Important: i any injury o		21. Signeture of Funaral Service Lice	McDon	Omal	10 C	Name end A	Addrass i O n		ty of	Mary1a	ind.	
ficate be executed in physician and its the burial transit	edical Examiner	Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disaase or Injury that initieted evants rasulting in daath) Last	b. Mox	Dua to	past (or es e consequence as e consequence)	uance of):	Kis	lisBirfe	exist		-	enpuse
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d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying course blander cancer Prestate cancer						in Part I.		obacco use c Yes 2 No		the cause of dec
The lew requires that the daath cer attending the bas been signed by the attending page 2 should be detached for use	Completed by	Prostate	cance	2					24a. Was perfo	an autopsy med?	cor	ra autopsy finding ilabia prior to apletion of ceusa laath?
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Physician: The this certificata rel director, pag	o Be	25. Was cesa rafarred to medical axeminar? 1 Yas 2	Hospital:	innationt OF] ER/Outpatient	2 004	Othar	26. Placa of Deal				
Attending Physic death. ector: Attar this by the funerel d	ation: To	27. Mannar Deum 1 Deum 5 Panding 2 Accidant invastigation	28a. Data (Mor	inpatient 2 C of Injury oth, Day Year)	28b. Tima of injury		injury e Work?	4 ID Nursing Ho	ome 5 Rasio 28d. Dascribe I			9
Per P	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ HomicIda datarminad	28a, Plac	e of Injury - At h ing, atc. <i>(Speci</i>	noma, farm, stre	eat, factory, of	ffice		28f. Location (S City or Tox	Straat and Num vn, State)	ber or Rura	Route Number,
Hospital or 24 hours afte Funerei Dir etely filled in	edicai	29a. Certifiar 1 certifying Ph (Check only one) 2 Medical Exam	niner: On tha b	a best of my kno easis of axamina nar statad.	owledga, daath ation and/or Inv	occurred at ta astigation, in	ha tima my opir	, data and place, nion, daath occur	and dua to tha red at tha tima,	causa(s) and m data and place	annar as st	ated. tha causa(s)
within 2 To the	Me	29b. Signetura and titla of certifiar	and mai	ar statad.		29c. Li	lcansa r	number		29d. Data sign	ad (Month, L	Day, Year)
		> In Trabelle	Enaa	grego	4 M	DI	136	57		Tanua	y 22	,1998
6		30. Nama and addrass of person who TI ABETTE T	complated ceu	sa of death (Ital	m 23a) (Type, F KESWI	Print)	06	140 H	STREET	BALTI	FORE	,1998
Sta Registr		31. Data filad (Month, Day, Year)	32. 1	Registrar's Sign	ature	/ -						

Julie Saidson-Randelle



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death 2. Dete of Deeth Month **Physician** 22, 1998 Poremski Victoria January 2:35 pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Avery Road Rosedale Baltimore Co. 5. Sociel Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 1 M 2 X F Months Days Hours Yrs. **Director** 63 220-30-0293 January 19,1935 Maryland death with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f ahow 1 ☐ Yes 2 X No Director Maryland Baltimore Co. Rosedale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8404 Avery Road 21237 United States Funeral Items 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status "natural", or item filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 M Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorcad White Hygiene. other than "naturs ent, the Medical E Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be file tment of Health and Mental Hy tant: If item 27 is marked oth Jury or other traumatic even Be Florian Rybczynski Bertha Aleksandrowicz P 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Albert J. Poremski/Husband 8404 Avery Road Rosedale, Maryland 21237 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cemetery 1/26/98 Rosedale, Maryland Gardens 21. Signeture of Funeral Servica Licensee Brian A. Willem 22. Name and Address of Fecility Leonard J. Ruck Funeral Home, Inc. Buon a. Willen 5305 Harrford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical Metastatic Cancer 5 months Lung Examiner Due to (or as a consequenca of): Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last and Due to (or es e consequence of) Box 68760. The law requires that the death certificate be Physician/Medical Due to (or es e consequence of) use P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 certificate hes 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28c. Injury et Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Yeer) 28d. Describe how injury occurred Aftert Division 5 Pending Investigation 1 X Naturel s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 2 4 ☐ Homicide filled in within 24 hours e To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 019714 untel 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State

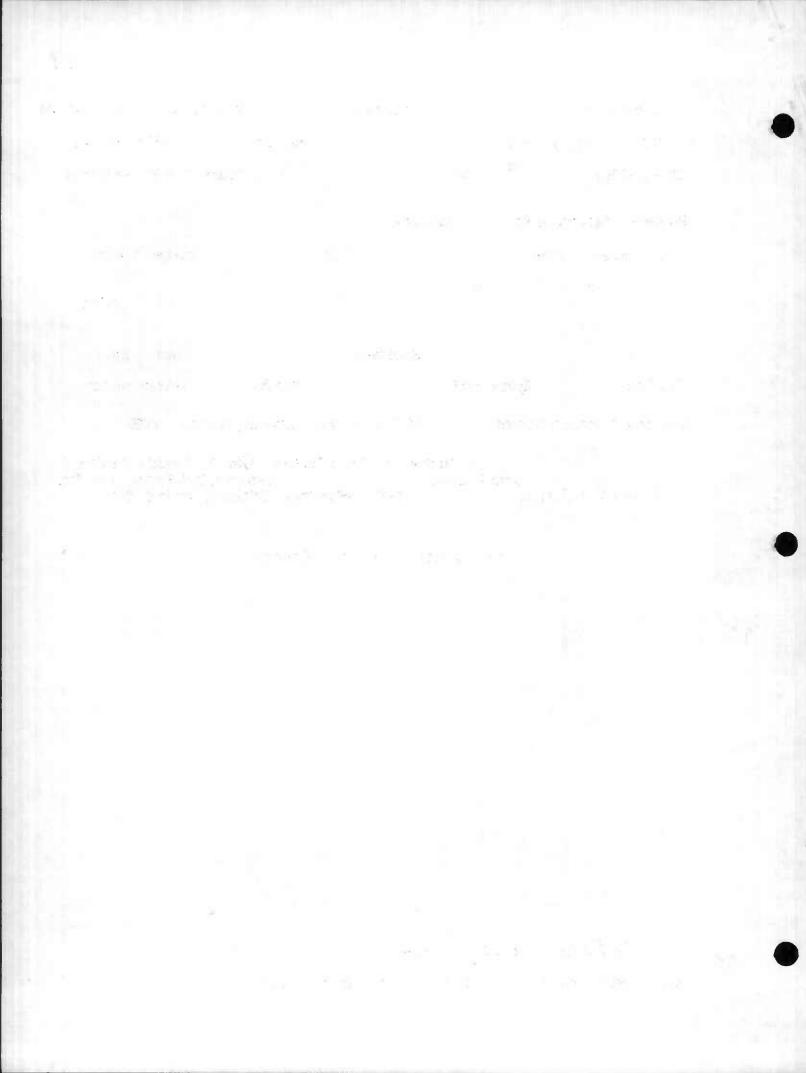
Registrar

31. Date filed (Month, Dey, Year) 27

Dr. Michael Purtell, MD.

4940 Eastern Avenue A2. Andistrar's Signature

Baltimore, Maryland 21224

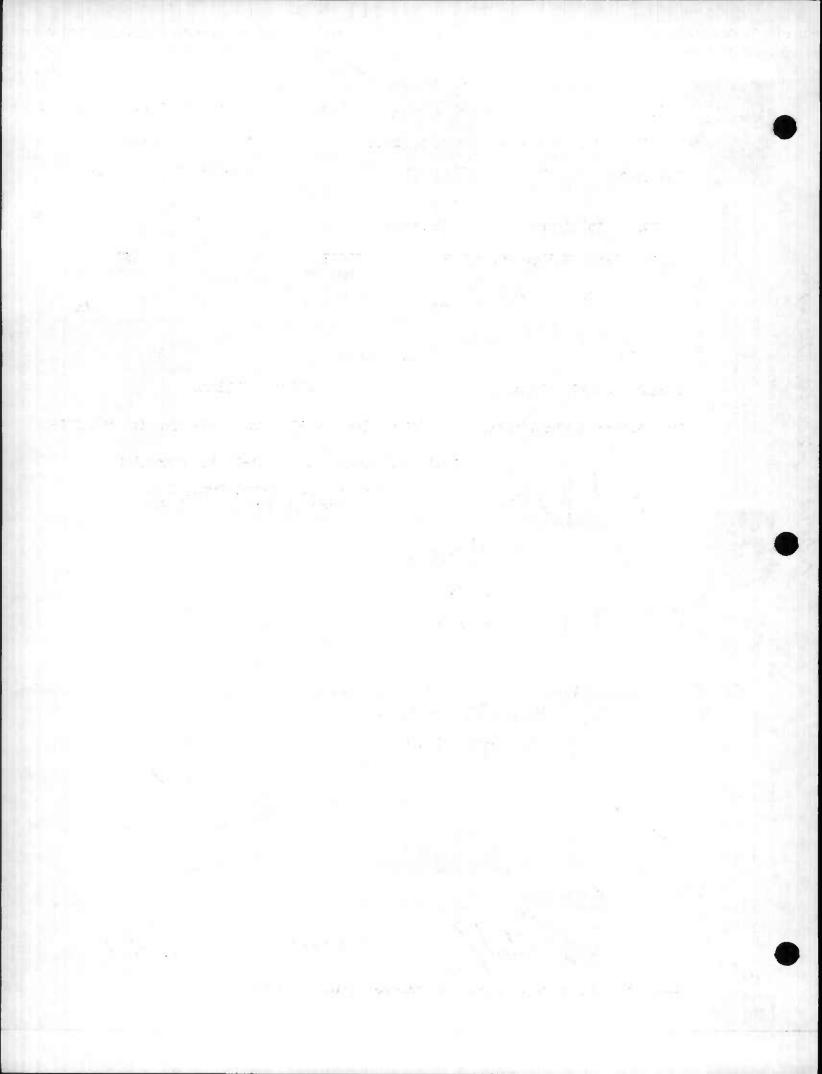


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

_		Decedent's Name (First, Middle, Last)			Certifica		Death		eg. No.	0 1 8	8 8
Physici /Media		Joseph	Samu	æl		2lum	e	Month JANUAR	Dey	Year	5:25PM
Examir		4e. Facility Name (If not Institution, give s	treet and number)				4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
	Н	GREATER BALTI		DICAL	CENTER	4 1/	TOWSON		BALTI		
Funeral Director		5. Social Security Number 6. Sex 235–28–3072 Usual Residence of Decedent	M 2□ F 7. Ag	e (In yrs. last bii 74	Yrs. Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey May 20	1923	9. Birthplace Country) Maryla	e (State or Foreign and
death with the Maryland ms 23a or 28a-f show	or	10a. State 10b. County		10c. City, Tow							Inside City Limits
the A	rect	MD. Baltimore	2	Timor	10f. Zij	Code			Og. Citizen of V		
3a or	D	2300 Dulaney Valle	0# 5d vc	207		1093		5		USA	
after deatl	Funeral Director		2. Wes Decedent I Armed Forces? 1.2 Yes 2 1.1 Yes, Give	Ever in U,S.	13. Was Dece If Yes, spe	dent of F cify Cubi	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - American k, White, etc.	
nours at	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes:	WII	TLI Yes	ZEJ NO	Specify:		Specify	Whi	te
in 72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondery (0-12)	ation completed) College (1-4or 5	+)	life. DO NOT u	rk done se retire	during most of work	ing	16b. Kind of Bu	isiness/indusi	iry
Hygie Hygie		12 17. Fether's Name (First, Middle, Last)		F1	ield Age	nt	18. Mother's Nam	e (First Middle	MVA Maiden Surnem	e)	
buid be filed with Mental Hygiena arked other than atic event, me	To Be	Joseph Samuel Plu	me Sr					illiams	naide. r Carrie	9)	
2 should and Men Is marke aumatic	Ě	19a. Informant's Name/Relationship (Typ		196	. Malting Addres	(Street	and Number or Rur		r, City or Town,	Stete, Zip Co	ode)
and 2 seaith ar		Mrs. Margaret Plum	-/Wife	2.3	300 Dula	nev '	Valley Ro	. #C207	Timoni	um .MD .	21093
es 1 and of Heaith f Item 27		20e. Method of Disposition		20b. Piece o	Disposition (Ne	ne of		Dete	20c. Location -		
Pag nent ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		op Servi			-23-98	Towson,	MD.	
permit. Pages 1 and 2 Department of Health inportant: if Item 27 is any injury or other tra		21. Signature of Funeral Service License	100		22. Name a	Tow	ss of Facility Son Funer	al Home	, Inc.		
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused	the deeth. Do	not enter the mod	YOY le of dyir	k Rd. Towng, such es cardiac	or respiratory err	21204 est,	Ap	oproximete terval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	V.	TACH	1						nset and Deeth
	e			Due to (or as a	consequence of)					1	
uted	Examiner	b.		U+	,					İ	
axecuration in a train		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	C.		consequence of)					1	
icate be axecuted physicial and transit sthe burial-transit	edicai	Cause (Disease or Injury that Initiated events			consequence of):						
ific and a second		resulting in death) Last								i	
attandin for use	Physician/M	0.								i	
the de	ysic	Pert II. Other significant conditions cont	-1			ause giv	ren in Part I.				e cause of death?
ires that the death cer signed by the attendin d be detached for use	by Pr	0	squalit.	- pre	work			1 U Y	es 2 No	3 Probeb	ly 4 ☑ Unknown
requ	Completed		Squater Multipl	e cu	A'O			24a. Was a perfor	n autopsy med?	avalle	eutopsy findings ble prior to letion of cause ath?
The law ata has paga 2	Com							1 🗆 Y	es 2 No	1 🗆 Y	es 2 No
sician: The certificata rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Deet	h (Check only or	18)	1	
hysic his ce	10	1 Ves 2 No Ho	ospital: 1 Inpatie	nt 2 ER/Ou	utpatient 3 De	OA Oth	er: 4 Nursing Ho	me 5 Resid	ence 8 Oth	er (Specify)	
To the Hospital or Attending Physician: The I within 24 hours aftar death. To the Funerel Director: After this certificate he completely filled in by the funeral director, paga		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Dey		Time of Injury M	8c. Injur Wor 1 □	yat k? Yes 2 □ No	28d. Describe h	ow injury occurr	red	
tal or Att rs after de el Directe led in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, fa :. (Specify)	irm, street, factor	, office		28f. Location (S City or Tow	treet end Numb n, Stete)	er or Rurai Re	oute Number,
To the Hospital within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one)	cien: To the best of er: On the basis of and menner sta	examination an	dor investigation	at the tir , In my o	ne, dete end place, pinlon, death occur	end due to the c red at the time, d	ause(s) end ma ate and place,	nner as state and due to the	d. e ceuse(s)
within To th	×	29b. Signature and title of certifier	111	/	29		e number	1	9d. Date agne	Month, Day	(, Year)
		1 1/	Mull			03	2639		1/22	197	
10X1		30. Neme and address of person who con	npleted cause of de	eath (Item 23a)	(Type, Print)				/ /		
10		Timothy Herlihy M.			imore Me	dica	1 Center				
Sta Registr		JAN 27 1998	32. Registra	Signature	andere.						

DHMH 16 Rev 6/95

Plume, Joseph



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Items: 10e, f per F.H. G-755 1/27/98 reb Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Daath 3. Tima of Death Month Dorothy C. Pennell January 24, 1998 9:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Undar 24 Hrs.
Hours Min.
March 28,1903

9. Birthplace (State State eswick Multi-Care Center 9. Birthplace (State or Foreign Country) If Undar 1 Yaar Social Security Number 7. Aga (In yrs. last birthday) 1 M 2 F Deys 139-54-7859 94 Yrs Usual Rasidenca of Dacadant 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Baltimore Co. Towson 10e. Straet and Number 10f. Zip Coda 10g. Citizen of Whet Counfry? 21286-7844 615 Chestnut Ave. 29 CEDAR AVE. 21204 3742 United States 12. Wes Decedanf Evar in U,S. Armad Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarlcan Indien, Biack, Whita, atc. 11. Maritai Status 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: 1 Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced White 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 02 Elementery/Secondery (0-12) Home Maker Own Home 17. Father's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Isaac M. Cocks Elizabeth A. Concklin 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Kenneth E. Pennell (Son) 29 Cedar Ave. Towson, Maryland 21286-7844 20b. Place of Disposition (Nama of cametery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 🗷 Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 01/26/98 Towson, Maryland 22. Nama and Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signature of Funarai Service Licensea Jeffrey L. Gair an 1050 York Rd. Towson, Md. 21204 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Is chemic Cerebral inforict Immediata Causa (Final diseese or condition rasulting In death) Orterisaclerotic cerebro - vascular disease Sequentially list conditions, if eny, laading to Immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 TNo 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 1 Tas 2 1000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminar? 26. Placa of Beath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? 1 5/Natural 5 [T] Pending

1 Yas 2 No

1 Dertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end mennar es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29c. License numbar

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Dey, Yeer)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

2

Examiner

Physician/Medical

by

Completed

Be

P

Certification:

Medical

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at

Hygiene.

h end Mental h

permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 ia m any Injury or other traum. once.

with the Meryland

should be filed within 72 hours efter death

Baltimore, Maryland 21215-0020

ettending physi 950 been signed by the should be deteched hes

director funeral After death. or Attendi efter death Director: A

Division of Vital Records,

To the Hospital within 24 hours or To the Funeral Completely filled

Hospital

7. BABELLE 31. Data filed (Month, Day, Yaar) State JAN 27

2 C) Accident

3 Suicide

29a. Cartifier (Check only one)

4 Homicide

29b. Signatura and titla of cartifian

30. Name and eddrass of person who completed cause of death (Itam 23a) (Type, Print)

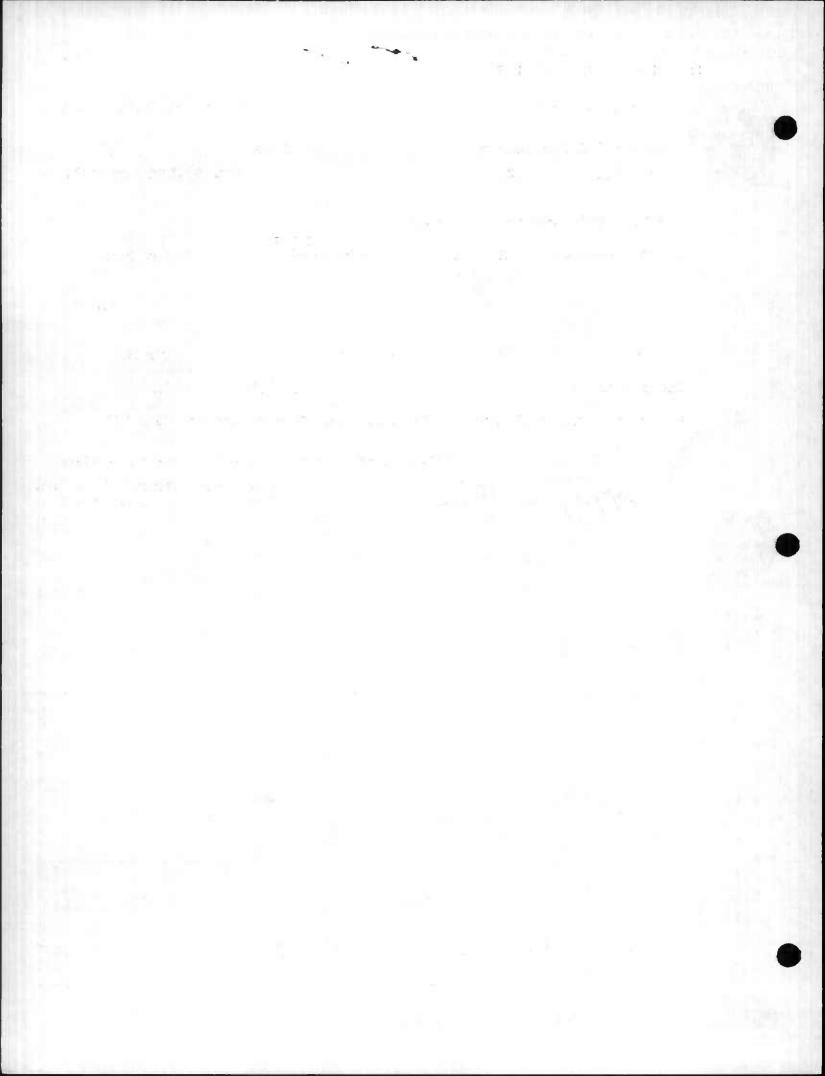
invastigation

6 Could not ba

GREGOR, KESWICK, 700 W. 40 th STREET, BALTO . M. 2121 32 Registrar's Signatura is la Davidan

28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

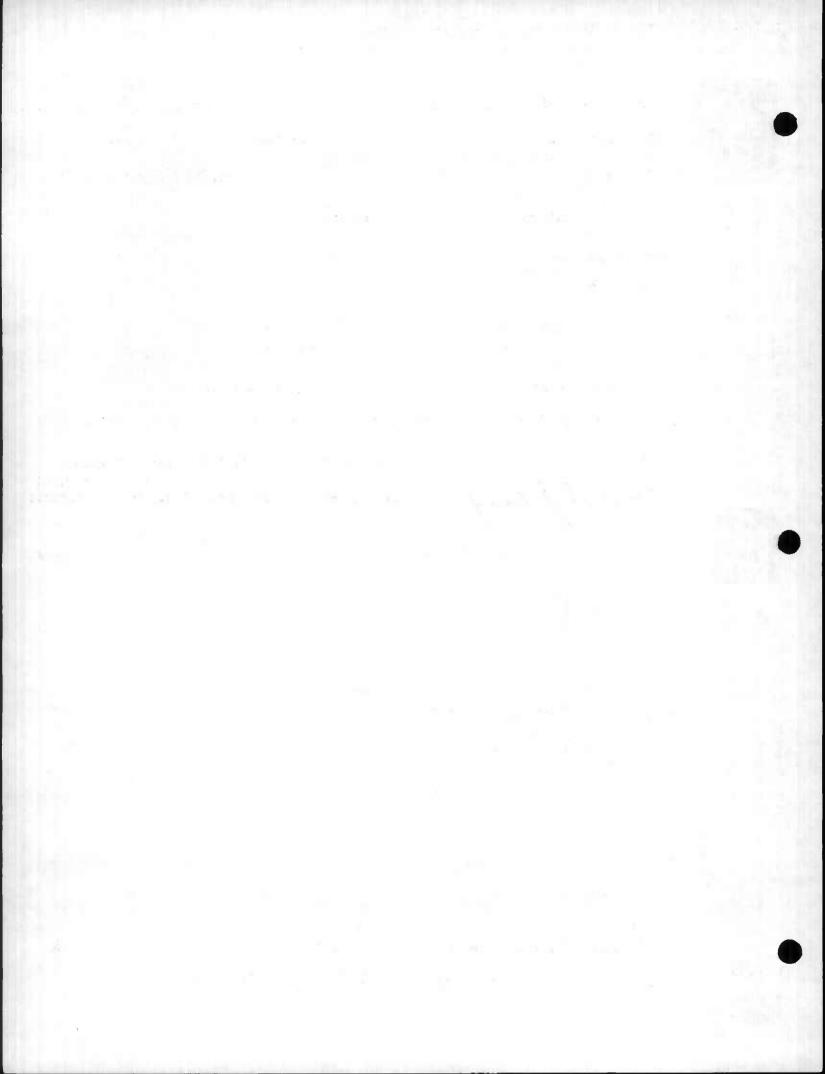
Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 22, 1998 James Alexander Pine, January 8:20 a.m. /Medical 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 13310 Fork Road Baldwin Baltimore If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Under 1 Year **Funeral** Birthplece (State or Foreign Country) Months Days Hours 1 ☑ M 2 □ F Yrs Director 217-20-4013 85 Aug. 12,1912 West Virginia Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Baltimore Baldwin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a deeth Funeral 13310 Fork Road U.S.A. 21013 12. Was Decadant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Rece - Amarican Indien, Bleck, Whita, atc. 11. Marital Status e filed within 72 hours effer al Hygiane. other than "naturel", or ite 1 Naver Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completad) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Attorney Legal 17. Father's Neme (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be f nent of Heelth and Mental I int: If Item 27 Is marked of 2 Lewis Alexander Pine Mary Conde Bridges 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if item 27 is any injury or other treu Charlotte W. Pine/Wife 607 Baltimore Ave. Towson, Maryland 21204 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or othar place) 20c. Locetion - City or Town, Stete Dete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1/28/98 Hilltop Service Corp. Towson, Maryland 21. Signature of Funerel Sarvice Licens 22. Name end Addrass of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Pert1. Entar the diseesa, or of inplications that caused the death. Do not anter the mode of dyling, such as cardiac or raspiratory errest, shock, or heart feilure. Listory one cause on earn line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseasa or condition resulting in death) /Medical Colon Cancer one year Examine Due to (or es e consequence of): Physician/Medicai Examiner Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last and Due to (or es e consequença of): P.O. Box 68760 thet the death certificate by Due to (or es e consequence of): use as ō Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Š Cancer, Bladder Concer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown been signed should be det Completed by Records, The law requires 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Wes an autopsy parformed? Caronary Artery Disease page 2 s certificata 1 Yas 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, p 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 28b. Time of Injury 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigetion 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner stated. 29a. Certifier Medicai 29b. Signature and title of cartifier 29c. License number 29d. Data signed (Month, Day, Year) rudues D50559 MD 22 1998 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Gardner 600 N walk Street Baltmare MD Z1287 Lawrence Gardner 32 Segletrar Daighauren Randon 31. Dete filed (MPATNPay2 Year) 1998 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

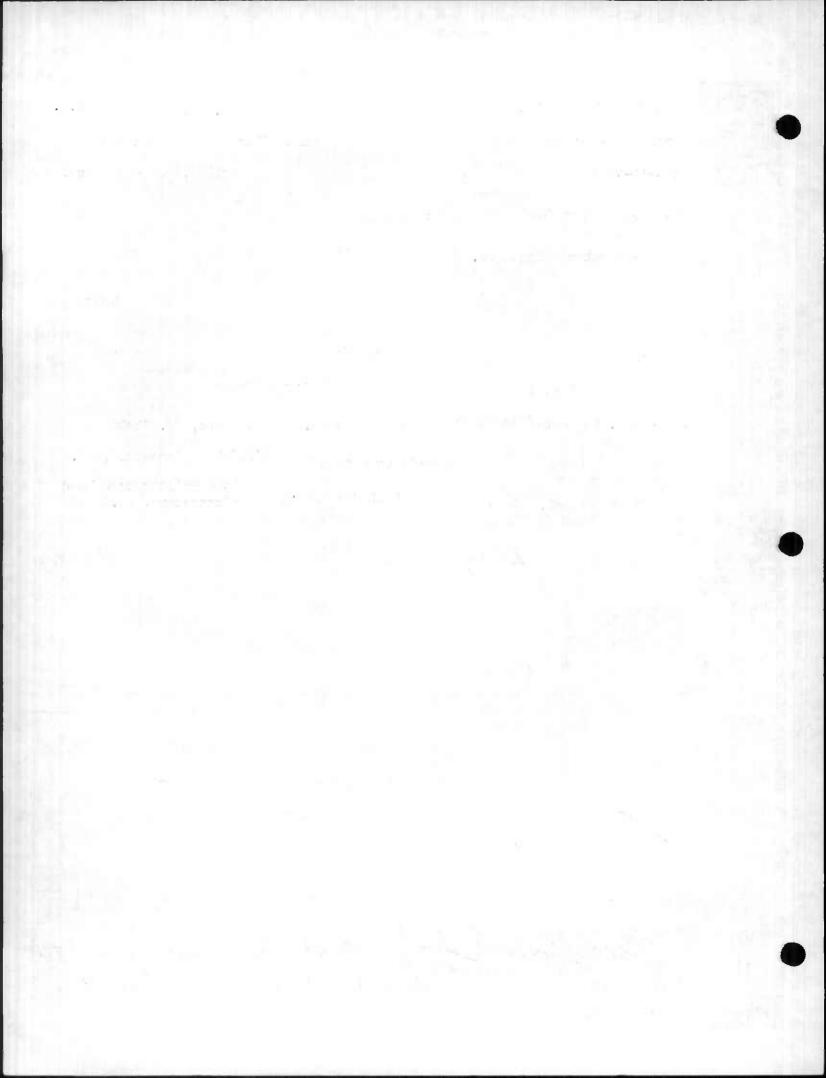
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I health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Marria 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	es? ☑No	,3.	13. Was Dec If Yes, sp		Specify:	Puerto Rica	n, etc.)		e - Americ ck, White, /: Whi	etc.
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tant: jury		4 □ Donetion 5 □ Other (S	pecify)		laney	valle	ey Mer	morial	1/3	0/98 1	imoniu	m, Mo	1.
Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee M			22. Name	end Addre	ss of Fecility		Home,			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	an '	ELIZABETH	RICE					Month	Dey	Yeer 8 P.M.		
/Medic							4h Cit. Tour		25,1998			
Examin	er	4e. Fecility Name (If not Institution, s						or Location of Deal				
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Funeral Director		5. Social Security Number 6. 105–12–4994 Usual Residence of Decedent		e (In yrs. les 88	Yrs.	If Under 1 Ye Months De		n. 8. Date of Bi Month, D. April	orth (1909) 1909	9. Birthplece (State or Forei Country) Waterbury, Con		
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288	Director	10e. Street end Number				10f. Zip Cod			10g. Citizen of V	What Country?		
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fatural, or items 23a or 28a-f show	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			Vas Decedent of Yes, specify C ☐ Yes 2 1 1	of Hispenic Origin? tuben, Mexicen, Pu- No <i>Specify</i> :	(Specify Yes or Ne erto Ricen, etc.)	14. Rac Blac Specify	e - American Indien, ck, White, etc. White		
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the state of	E	12 Grade	College (1-401)	, ,	Но	usewife	2		Ow	n Home		
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th and Man 7 Is marke traumatic		19a. Informant's Name/Reletionship			19b. Mailin	a Address (Str	eet end Number or	Rural Route Numb	er, City or Town.	State, Zip Code)		
e de la		Dolores E. Schwa		er)		Sylvale						
DE E		20a. Method of Disposition	162			sition (Neme of netory or other)		Baltimor		City or Town, State		
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tant		4 Donetion 5 Other (Spec		Car		Cremati	Lon	1,20,00	Hamps	ceau, nu.		
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nysician Medicai		Immediate Ceuse (Final)	16.						Intervel Between Onset end Death		
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the att	Sici	Part II. Other significent conditions	contributing to death b	ut not resulti	ina In the un	deriving cause	given In Part I.	23b. Did	tobacco use co	ntribute to the cause of deat		
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page	No.							10	Yes 2 No	1 ☐ Yes 2 ☐ No		
certificate rector, pag	Be	25. Was cese referred to medical					26. Place of D	eath (Check only	one)			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** Dev RIAG 4:45PM 1608 JANUARY 23 /Medical 4c. County of Deeth 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** | BALTIMORI | If Under 1 Year | If Under 24 Hrs. | 8. Do | Months | Deys | Hours | Min. | (A HOPKINS-BAYVILW SOHOL 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) **Funeral** 1 M 20 F Yrs Director 25 AUG-13 1972 DIXE Usuel Residence of Decedent the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show I is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 Yes 28 No Director A USRSTARO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 76010 "natural", or Items 23a 83-H Ida ODIX35 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Mantal Status pemil. Peges I and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or hereny injury or other traumatin. I ☐ Yes 200 No If Yes, Give Yeer or Dates: Never Merried 2 Married Baltimore, Maryland 21215-0020 Yes 2 No Specify: Specify: (by 3 Widowed 4 Divorced EXICAC Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SICRETARIAL ATTORALY - LAWYER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be VICEDIE 2 ANIOZAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) QUERETARO, () EXICO
Date 200. Location - City or Town, State 76010 20b. Placa of Disposition (Name of MR+MRS. VICENTE 20e. Method of Disposition cemetery, cremetery or other plece) 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State JANSI 4 ☐ Donation 5 ☐ Other (Specify) CREMATERY 1998 GNATIARO MORSLAS Funeral Service Licensee 22. Neme end Address of Facility ORILS 21334 8800 HARFORD ROAD andr 1ARYLAND don 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or hear feilure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner 2400 GW Due to (or es e consequence of) Examiner no mok Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 physiciar Physician/Medical the Due to (or es e consequence of) USB ŏ Records, P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t d be detach 1 Yes 28 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? peen hes page Yes Yes 2 🗆 No 1 ☐ Yes 2 No certificete Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 250 No Inpatient 2 □ ER/Outpetient 3 □ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending Investigation 1 Neturel death. To the Hospital or Attendia within 24 hours effer death. To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Secretifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steled.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

JAMUARY 23 1998

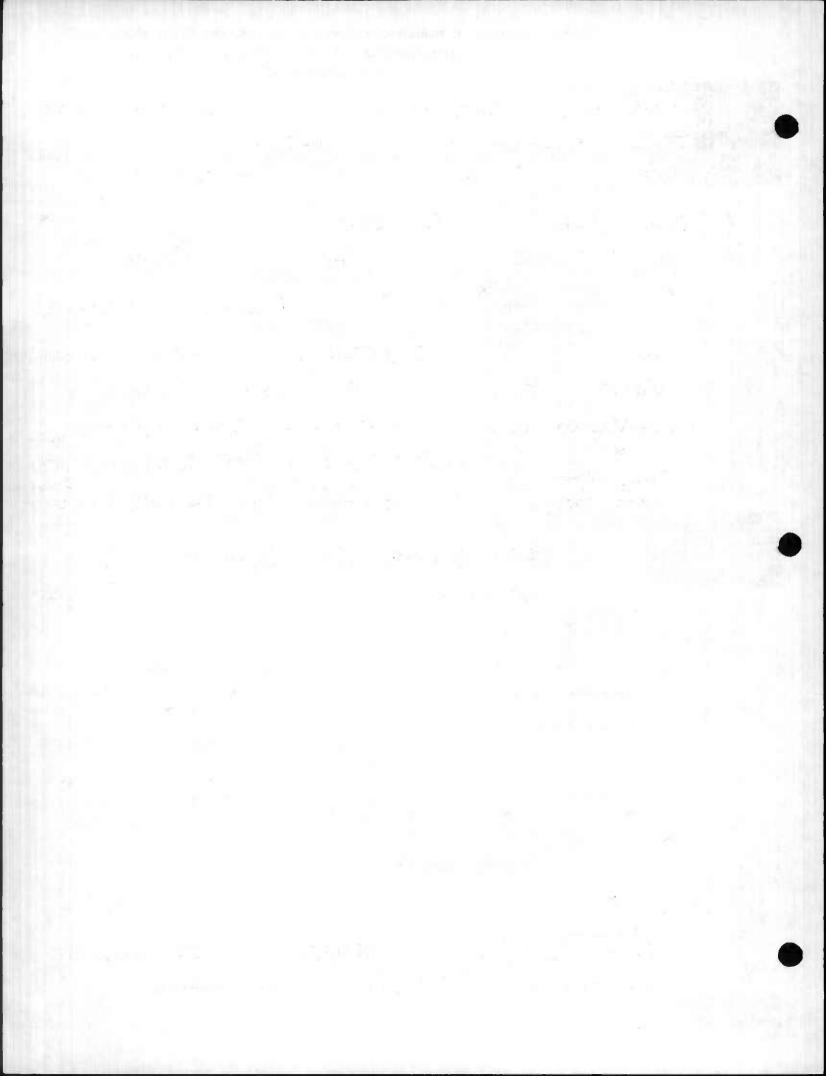
8 State

Registrar

29b. Signature

GOOCH TINGLEY JOHN HOPKING -BAYVEW DRWHITTEMORE 31. Dete filed (Month, Day, Year) 32 Registrar's Signeture ina Davidson-Randolle 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 5.18 Per FH Film G-755 1-27-98RC 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** SANDI ROllins :45 P.M. JANUARY 24 98 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMOVE Medical Center Baltimore Mercy 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Day, 9. Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 16-01 9378 10M 2□ F 216-01-9378 Usuel Residence of Decedent Yrs. Director the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Tyes 2 No Director NA 10 MORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Charles St. N 524 21201 NSA **Неття 23**а Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Maritel Stetus e filed within 72 hours after all Hygiena. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Worker obstruction ONStruction 15+V NA . Pages 1 and 2 should be fill, mant of Health and Mental Hiant: If item 27 is marked oth jury or other traumatic even 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Rosanua ZUILLO ROLLINS Eliaah 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stell Tip Code) Rollins 524 N . Charles Md 21201 AVIS Dilto 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Suriel 2 Cremetion 3 Removal from State permit. Page Department of important: If any injury or once. .29.98 4 ☐ Donetion 5 ☐ Other (Specify) nlem. Kanda HUT 21. Signature of Funerel Service License 22, Name and Address of Fecility last Fuc. Aus Balto Home Wm C. Wn C March trin Ham 21215 Approximete 23a. Part. Enter the classe, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Respiratory Failure Immediate Ceuse (Final disease or condition resulting In deeth) /Medicai Examiner Examiner PNEUMONIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting In deeth) Lest Due to (or es e consequence of): PLLMONALY DISCASE obstructive P.O. Box 68760, Chronic Physician/Medical Due to (or es e consequence of) the phys Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the Artery 1 Yes 2 No 3 Probably 4 Unknown DISCASE COTOVOLY Records, by Hypertension 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes an eutopsy performed? page 2 s 1 ☐ Yes No 1 Tes cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Aftar this cartifica completely filled in by the funeral director, t Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpetient 3 DOA 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

[2] Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier 29b. Signeture end title of continue 29c. License number 29d. Date signed (Month, Dey, Year) P120007 JANUALY/24

State Registrar

31. Dete filed (Month, Day, Year)

JAN 27 1998

32. Registrar's Signeture

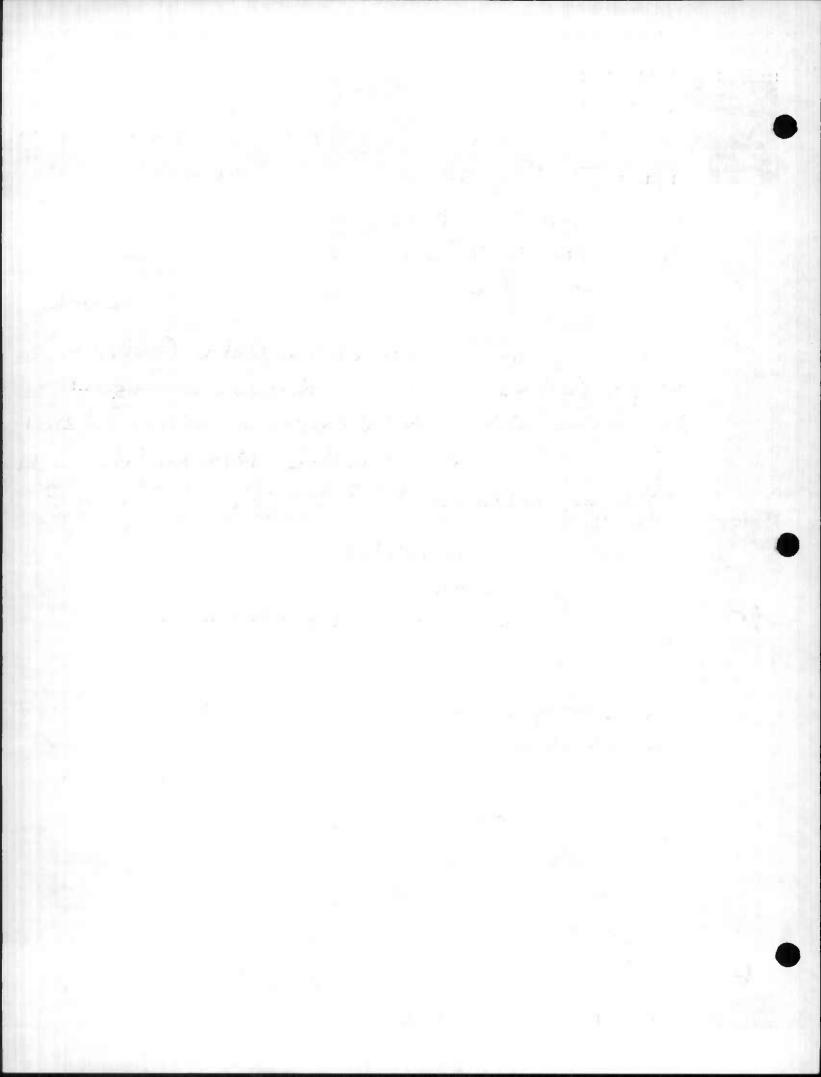
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Michael FAUlkner M.D

Bacto. MD

21207

301 St. PAUL PLACE

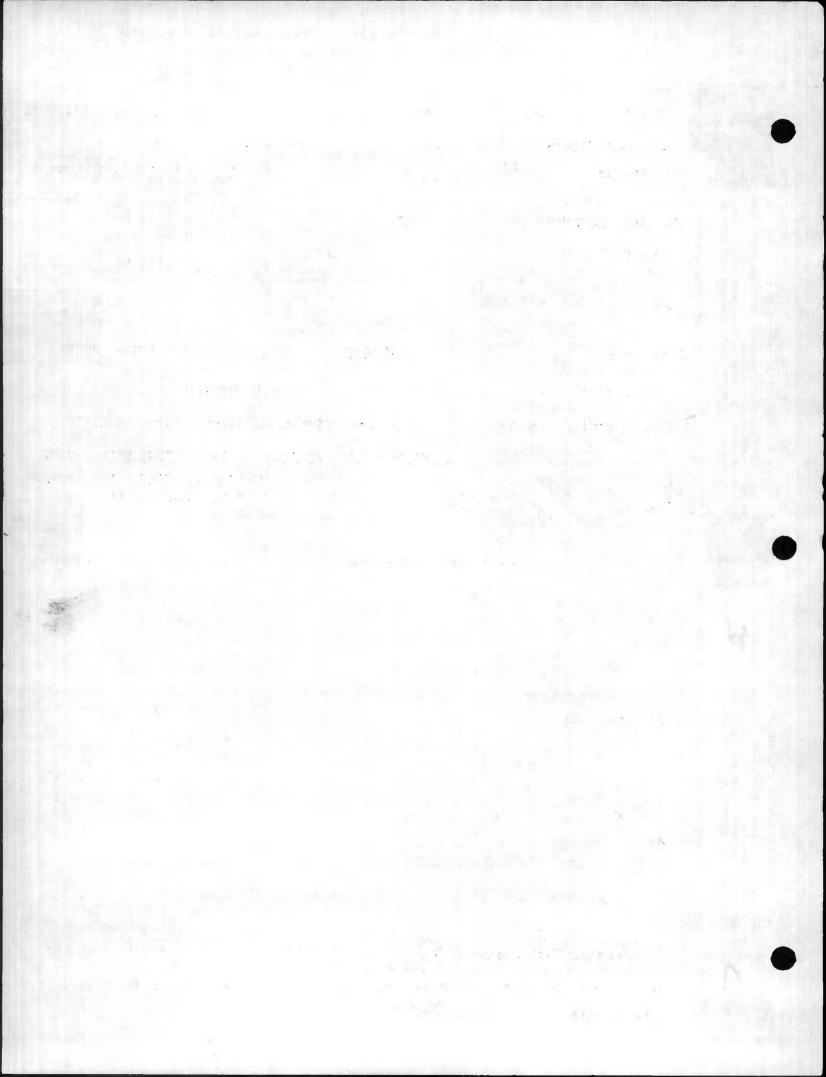


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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Margaset Robin 4e. Fecility Name (Illoot institution, give street and number) Robinson 121 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Multi-MEdical-GENESIS Eldercare TIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 1□M 2XF Birthplace (State or Foreign Country) 218-30-606 Months Deys UNKNOWN Usual Residence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 ☐ Yes 2 KNo BALTIMORE HEREFORD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16720 HEREFORD ROAD 21111 U.S. OF Α. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surneme 17. Fether's Name (First, Middle, Last) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ARNETTA C, WALKER (CARE PROVIDER) 16720 HEREFORD RD. HEREFORD, MD. 21111 20b. Place of Disposition (Neme of cermetery, cremetory or other place) KING MEMORIAL PARK 1/27/98 BALTIMORE, MD. Co. 20c. Location - City or Town, Stete BALTO 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility LEWIST. GWYNN FUNERAL HOME 4517 PARK HEIGHTS ther the mode of dying, such es cardiac or respi BALTO . MD 23e. Part1. Enter the disease, or complications the laused the deeth. Do not enter shock, or heart feilure. List only one cause Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 28. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 Yes 2 No Investigation

Examiner Examiner or Attending Physician: The law requires that the death certificate be asscuted Box 68760, Physician/Medical for use as P.O. Records, Completed by page 2 certificate of Vital Certification: To After Division offer death. Director: Aft In by the fur

Physician

/Medical

Examiner

Funeral

Director

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permit. Page Department of Important: If any injury or once.

Physician /Medical

Pages 1 and 2 should be

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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25. Was case referred to medical examiner? 1 Yes 2 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be determined 3 Suicide 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29e. Certifier 1 Cartifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

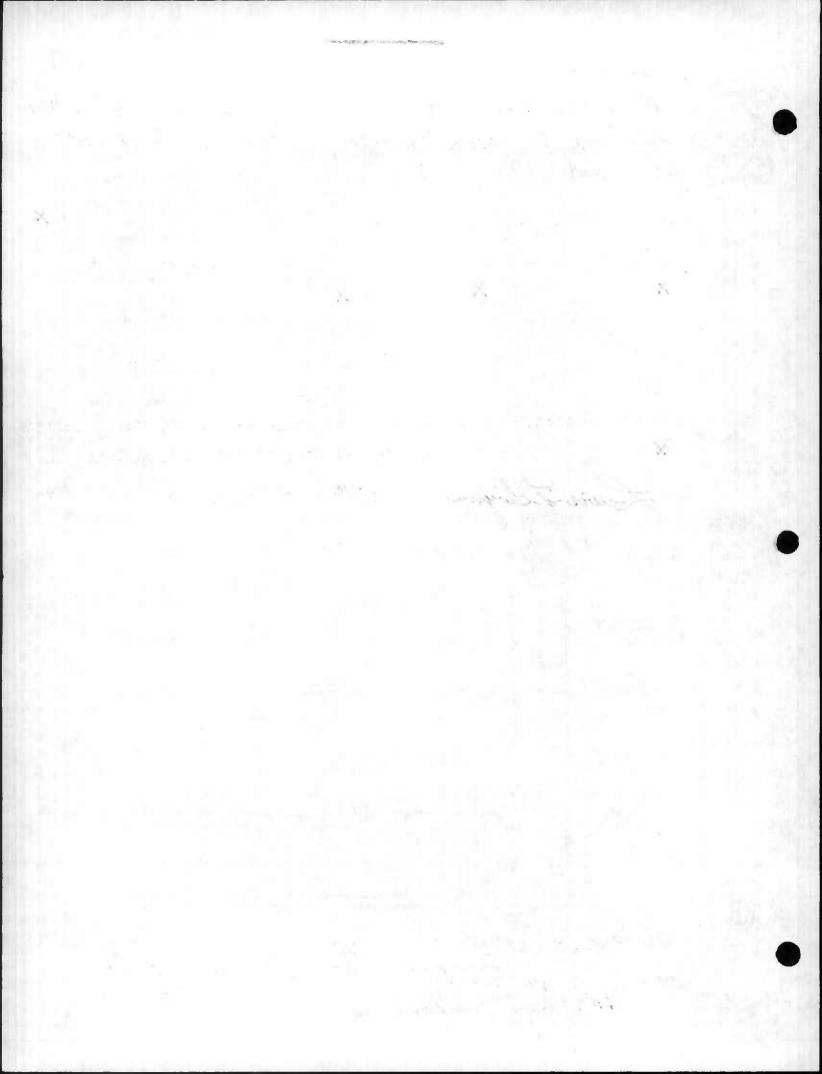
29b. Signeture end title of cartifier 29c. License number

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 903.

State Registrar

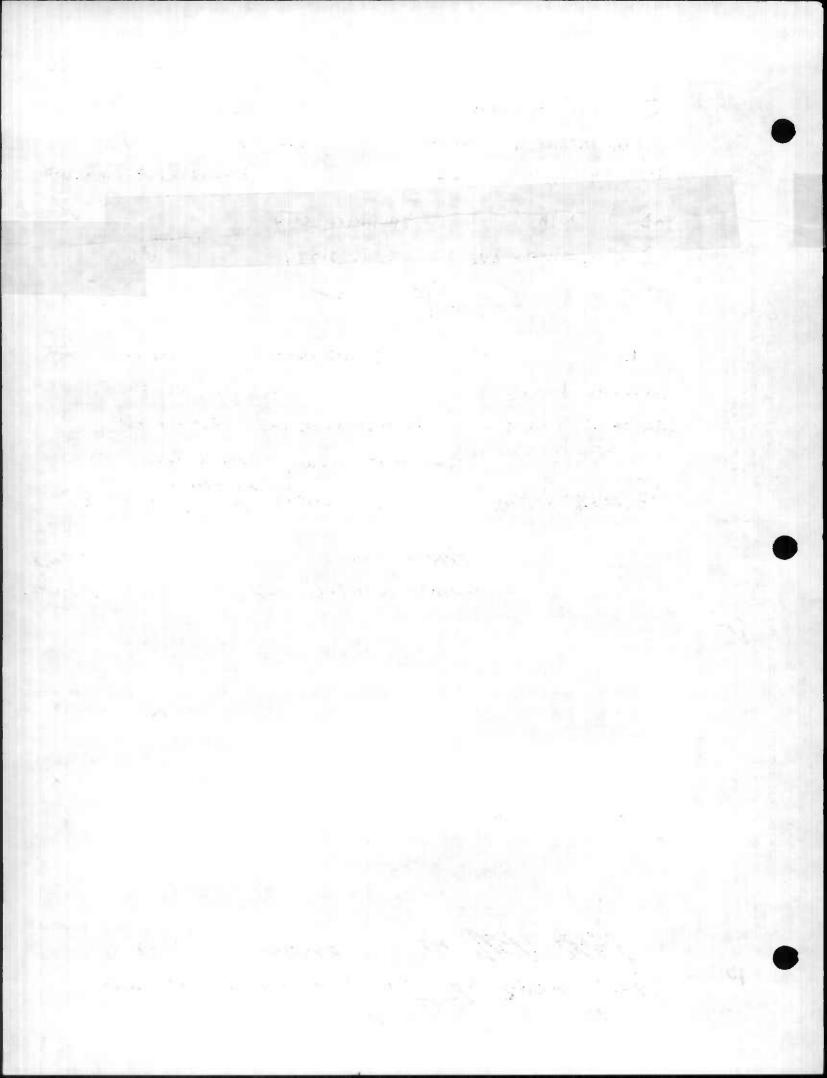
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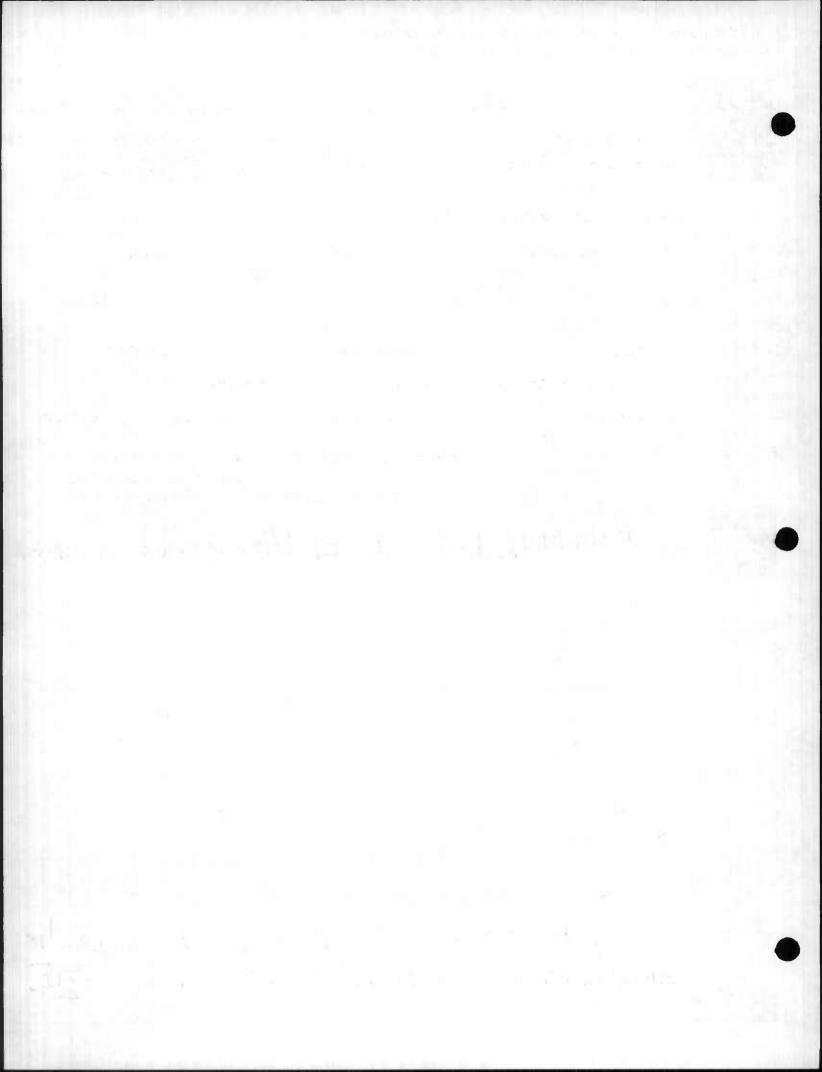
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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1000	edical	(Check only 2 Medical Exam)	ner: On the basis of examin						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29b. Signature and till of podifier	1101		29c. License number	772	29d. Date signe	d (Month, Dey, Year)	
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State of Maryland / Department of Health and Mental Hygiene 8 0 | 8 2 9

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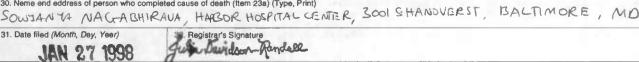
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Dey 23 1998 **Physician** SHORT MATILDA 10:50 a.m /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTER HARBOR HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 178 28 9835 June 4, Pennsylvania Director 1936 Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 620 Maude Avenue 21225 U.S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Neseny Injury or other treumetic event, the Medical Exempton 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) Coilege (1-4or 5+) Cashier Farm Fresh 8th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Catherine DeModica Guisippie Tornarealli OL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Vicky Bell / daughter 2938 Charleston Avenue Baltimore, Maryland 21227 20b. Piece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1/27/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. emusery 4001 Ritchie Highway Baltimore, Md. n 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA DAY Examiner Examiner PNEUMONIA INEEK attending physician and for use as the bund-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760, Physician/Medicai that initieted events resulting in death) Last Due to (or es a consequence of): ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown ARTERY DISEASE CORONARY Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed OBSTRUCTIVE PULMONARY DISEASE has 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ↑ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Dey Yeer) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: After 1 1 Naturel 5 Pending investigation death. 1 Tyes 2 No 2 ☐ Accident or Attendent efter death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours e Funerel D 29a. Certifier 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) AS-2441614-25 23/98 N-Soujange, HOUSE STAFF

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State

Registrar

31. Date filed (Month, Dey, Yeer)

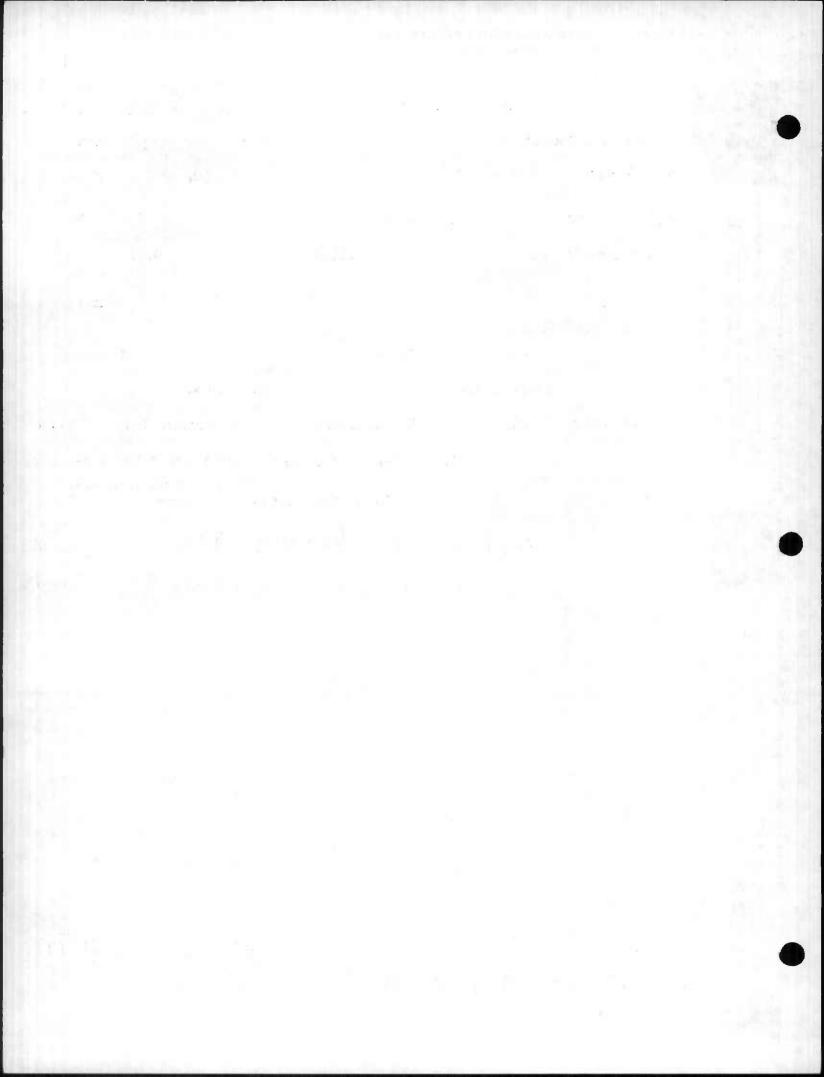


30. Name end eddress of person who completed cause of death (ttem 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 8

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Buer wen, Maxwel

Registrar

DHMH 16 Rev 6/95

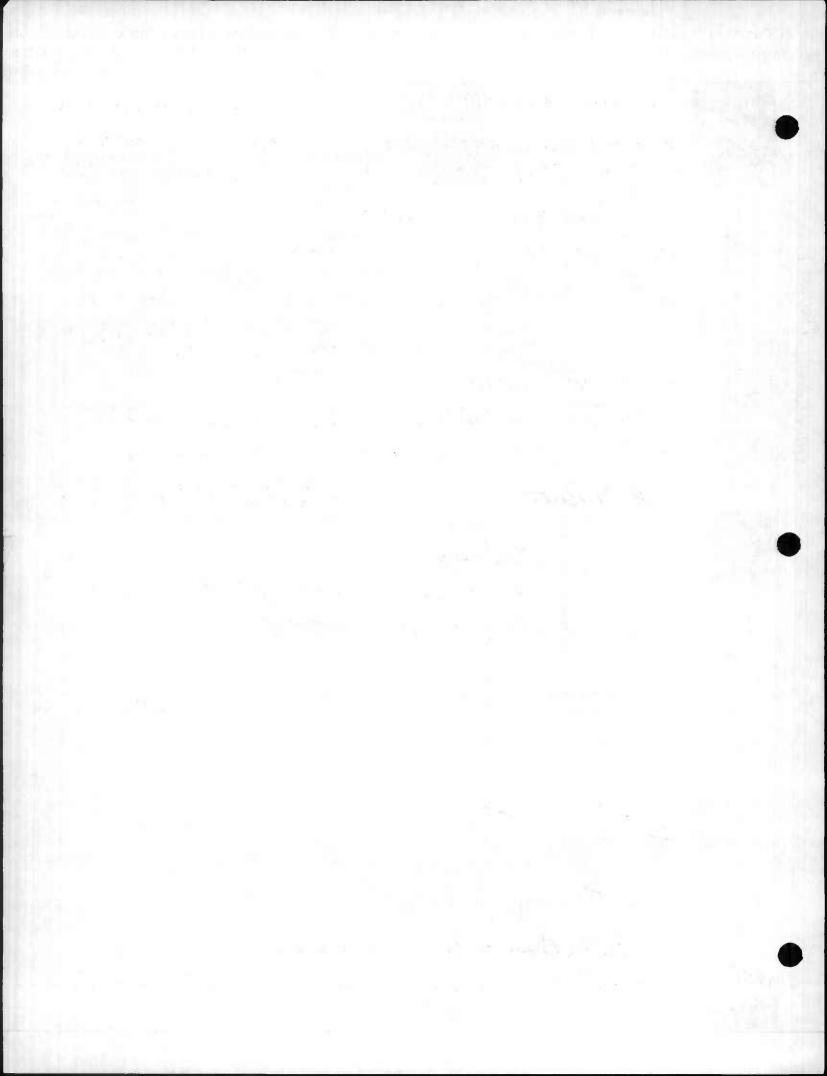
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** E. MAXWELL SAUERWEIN JANUARY 24 1998 10:10 pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 7. Age (In yrs. lest birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Months | Deys | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex XX M 2□ F Birthplece (State or Foreign Country) **Funeral** Months Deys 530-18-0038 89 Yrs Director 02-16-1908 MARYLAND Usual Rasidenca of Dacedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show MD. BALTIMORE COCKEYSVILLE 1 ☐ Yes X X No Directo 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 72 hours after death with 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinor must be a 13801 YORK ROAD 21030 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? XXYes 2□ No If Yes, Give Year or Dates: W • W • II 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes X X No Specify: by XXWidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry JOHNS HOFKINS Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) PLUS ADMINISTRATIVE ASSISTANT UNIVERSITY 5 permit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: If them 27 is merked oths any Injury or other traumetic event. 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be ROBERT TAYLOR SAUERWEIN MAXWELL ANNA 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 0 3 19e. Informent's Name/Ralationship (Type, Print) TRUST KENNETH D.HORNSTEIN OFFEICER, FIRST NAT. BANK, P.O. BOX 1596, BALTO., MD. 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete GREEN MOUN' CEMETERY 1-30-98 BALTO., MD., 21202 XX Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
HENRY W. JENKINS AND SONS CCMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 21. Signeture of Funerei Service Licenses R. S. Butt 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediata Ceuse (Finel diseese or condition resulting in daath) SEPSIS Examiner Due to (or es e consequence of): Examiner DISEASE AND LIVEN Sequentially list conditions, if eny, laading to Immediata cause. Enter Undarlying Causa (Disaese or Injury that Initiated evants resulting in deeth) Lest BSTRUCTIVE Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequence of usa 20 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of daath? 24a. Wes en eutopsy Completed has page 2 cartificata 1 Yes X2 No 1 ☐ Yes 2 ☐ No funaral director. 25. Was casa referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Attending 1-Naturel or Attending after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 Homicide Hospital 24 hours a Funeral Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, deta and place, end due to tha cause(s) and menner es steted.

| Certifying Physician: To tha best of my knowledge, deeth occurred at the time, due to the cause(s) and menner es steted.

| Certifying Physician: To tha best of my knowledge, deeth occurred at the time, due to the cause(s) and menner estated.

| Certifying Physician: To tha best of my knowledge, deeth occurred at the time, due to the cause(s) and menner estated. 29a. Certifier Medical complataly (Check only one) To the I 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) 1241 30. Nama end addrass of person who complated causa of daath (Itam 23e) (Type, Print) 3346 KONEN ND APENMILLRD KODEN X 31. Data filed (Month, Day, Yeer) 32. Registrer's Signetura which Da Adson Andree

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Somerville ames amay 1998 02:10a.m. /Medical 4a. Facility Name (If not institution, give street and numbar, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner n/a Hospita Baltimore DANS CITY 5. Social Security Numba If Undar 1 Yaar 7. Age (In yrs. last birthday) If Undar 24 Hrs. 8. Data of Birth (Month, Day Birthplace (State or Foreign Country) 212-30-8368 Months Days Hours 100M 2□ F 64 Yrs. 20, 1933 Usual Rasidence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Director n/a Baltimore Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 145 N. Culver Street 21229 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 12∑Yas 2 □ No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 1 Nevar Married 2 Married 1 ☐ Yes XX No Specify: **Black** þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Merchants Terminal Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Forklift Operator Refridgeration 17. Fether's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maidan Surnama) Walter R. Somerville SR. Bettie L. Hunt 19e. Informant's Name/Reletionship (Type, Print) sister 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Bessie S. Brown 1111 Pleasant Valley Drive Baltimore, Md. 21228 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Serial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specific) Garrison Forest Veterans | Jan. 26 Owings Mills, Md. 22. Name end Address of Feolility Nutter Funeral Homes, Inc. 21. Signature of Funeral Seguina Lical 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Entar tha disease, or complications that can shock, or heert feilure. List only one cause or make death. Do not anter tha moda of dylng, such es cerdiac or raspiratory arrast, Immediate Cause (Final disease or condition resulting in death) Ischemic Bawe Dua to (or as e consequence of): failure Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Lest Due to (or es consequence of): Kins Hody (13 eas eous es a consaguance of) 13 ease eour Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Tes 2 No 3 Probably 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Inpatiant 2 ER/Outpetient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 3 DOA 27. Manner of Death 1 ONetural 2 Accident 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

Examiner Box 68760 Physician/Medical P.O. been signed by the e should be deteched f Division of Vital Records. þ Completed funeral director, Be To this Certification: After To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At

Funeral

Director

with the Maryland

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other tre

Physician /Medicai

Examiner

Maryland 21215-0020

6 Could not be determined

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29c. Licanse number

29b. Signature and title of certifiq

27

HOSROW 31. Dete filed (Month, Day, Year)

Resident 30. Name end eddress of person who completed ause of deeth (Item 23e) (Type,

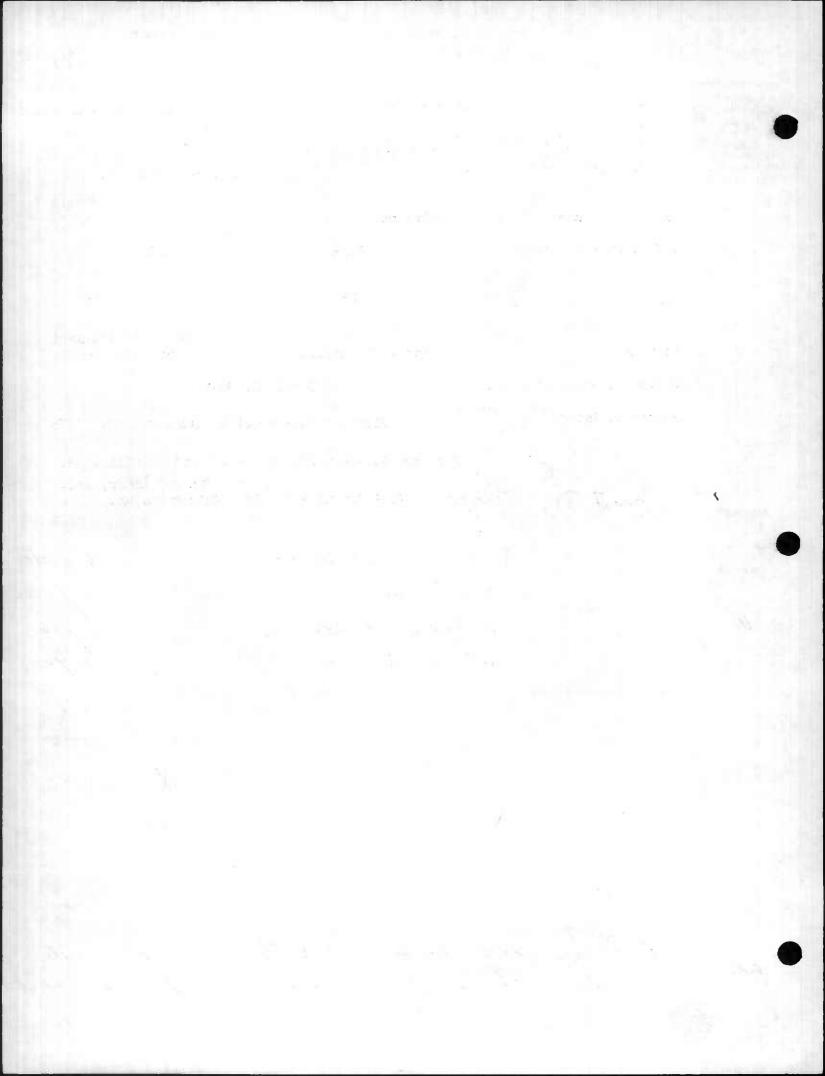
lanuary 22,

29d. Date signed (Month, Day, Year)

Registrar

Medical

32 Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item; 7, per F.H. G-755 1/27/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 05 Stone lam Barbara Januar 23 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins
5. Social Security Number 6. Sex Center Baltimore N/A Geriatric If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1 M 2 X F Months Deys 20 Yrs. 217-58-6992 42 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD N/A Baltimore 1 XYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5505 Bayview Circle 21224 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 end 2 should be filled wi tment of Health end Mental Hygien tant: If Item 27 Ia marked other th lury or other traumatic event, Illa Taxi Driver Taxi Service Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be John Carroll Fairbank Mary Agnes Turner 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1924 Makiki Heights Dr. Honolulu, HI 96822 ce of Disposition (Name of Date 20c. Location - City or Town, Stete John C. Fairbank/father 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Dicremation 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. Metro Crematory, Inc. 01/24/98 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral 22 Name end Address of Facility
Cremation Society of Maryland, Inc. McDonald Dawn F 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Cerebrovascular disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. ocaine Physician/Medical Due to (or es e conseguence of): for use been signed by the e should be deteched if Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed by 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. 25. Was cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 2 Accident 5 Pending Investigation s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined within 24 hours efter dea To the Funeral Director completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homlcide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a, Certifier Medical (Check only one) the 29b. Signature end title of perifier 29c. License number 29d. Date signed (Month, Dey, Year)

31. Date filed (Month, Day, Yeer) State Registrar

Yeer) 32 Regular's Signature

30. Name end eddress of purplen who completed cause of deeth (Item 23e) (Type, Print)

5505 Hopkins

40

Vian Circla

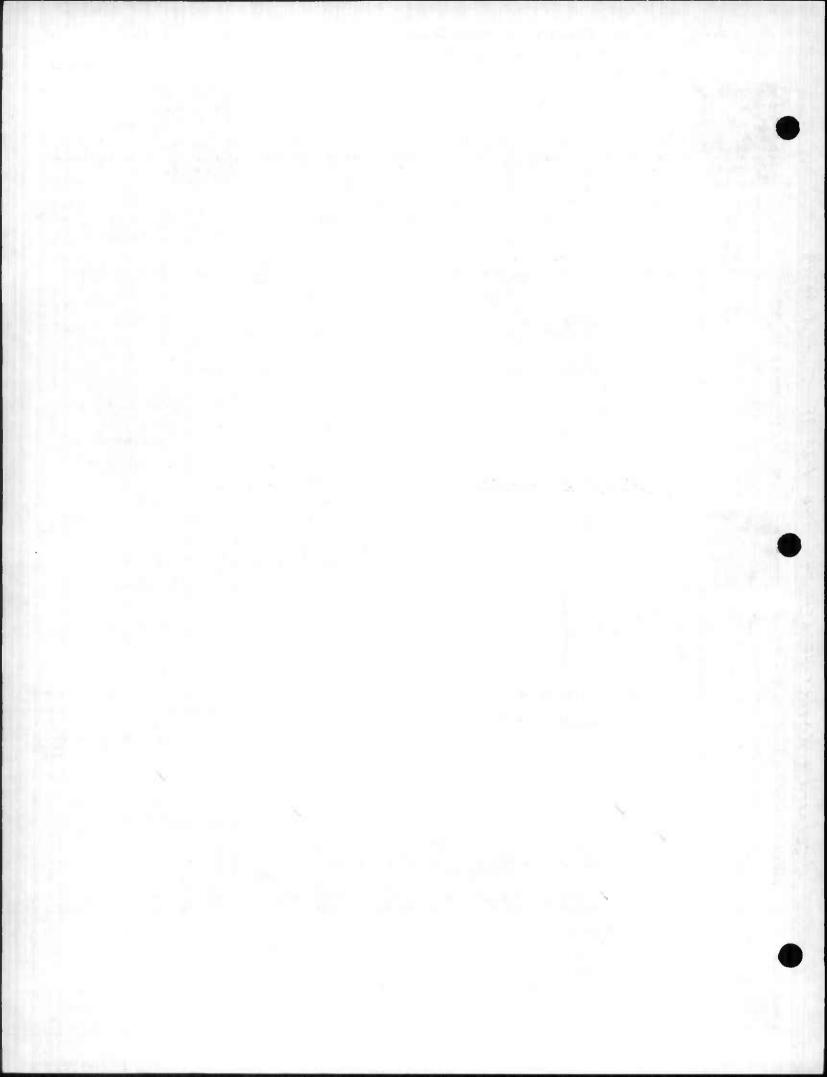
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State of Maryland / Department of Health and Mental Hygiene

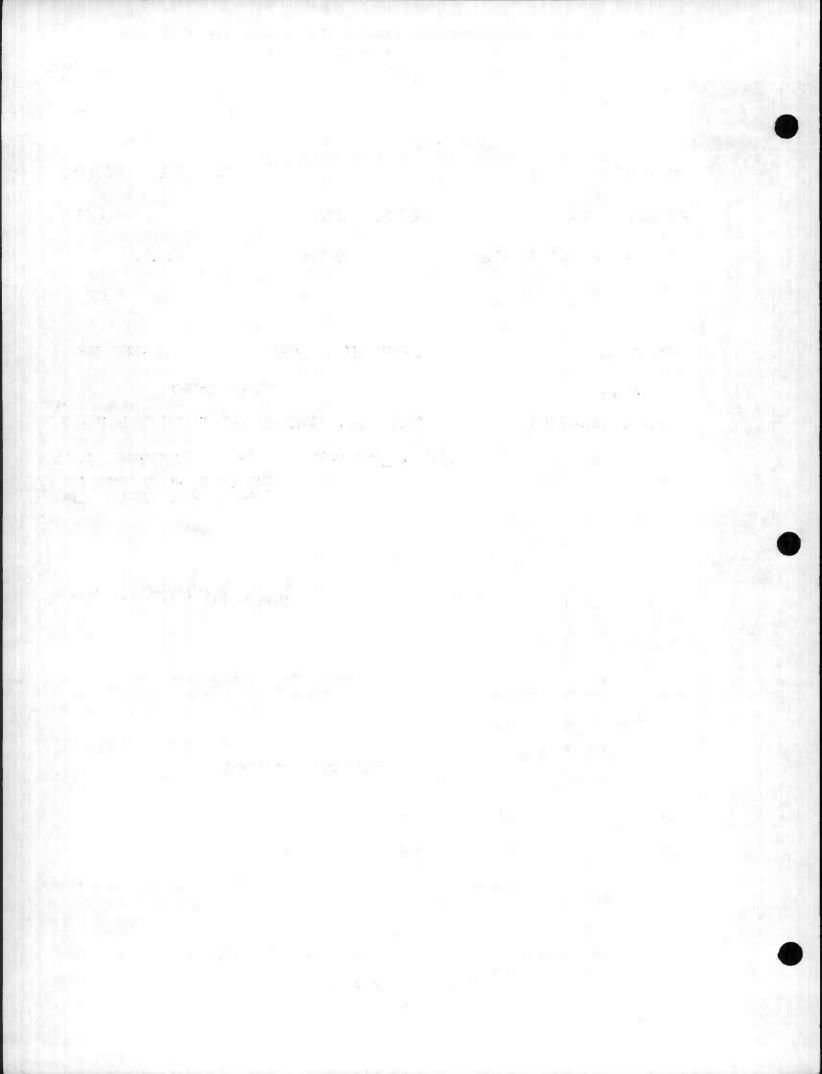
							tificate of		Wientarriy	Reg. No.	UI	835
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	uneral irector		5. Social Security Number 216-09-2016	_	e (In yrs. last i 81	birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hours Min				ace (State or Foreign ry) sylvania
pue	3		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, To	we or Loc	ation					
Maryle	e or 28a-f show be notified at	or	MD Baltim	ore			11stown	1			10	od. Inside City Limits 1 ☐ Yes 2 No
the l	7 28a	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Whet Count	ry?
th with	23e o	al D	5412 Old Court	Road			21133	3		USA		
17715-0020 within 72 hours efter death with the Marylend	or Items	/ Funeral	11. Maritel Status 1 Never Married 2 Married	12. Wes Decedent I Armed Forces? 1 Yes X	Ever in U,S.		/as Decedent of H Yes, specify Cub. ☐ Yes 2 No	dispenic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No orto Rican, etc.)	o- 14. Rac Blac	e - America	etc.
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ZTZTS-UUZU d within 72 hours el	an collection	Completed	15. Decadent's Ed (Specify only highest gra	de completed)	16	Se. Decede (Give k life. D	ent's Usuel Occup ind of work done O NOT use retire	ation during most of w d)	orking	16b. Kind of Bu	isiness/Indi	ustry
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E 01 0	tem 27 is m other traum		Patricia S. Kohne						Ru <i>rel Route N</i> um <i>t</i> estminst			Code)
1 end	item 2 other		20e. Method of Disposition	/ Stepaadgi	20b. Plece	of Dispos	ition (Neme of		Date	20c. Location -		vn. Stete
mit. Pages 1 er	,		1 Buriel 27 Cremetion 3 4 Donetion 5 Other (Specific	Removel from State			etory or other ple ematory,	•	126/09			
permit. Page Department	ortant: / injury 28.		21. Signeture of Funeral Service Licer	509/11	nett	22.	Name end Addre	ss of Fecility		Baltim		MD
2 2 2	on you		George E. Macl			Cr	remation	Society	of Mary Baltimo	land, In	1C.	
			23a. Pert1. Enter the disease, or com shock, or heart feilure. List only		the death. D	o not ente	r the mode of dyir	ng, such es cardi	ac or respiretory e	orrest,		Approximete
/M	sician ledical aminer		Immediate Cause (Final disease or condition resulting in death)	. Chro	nic	ol	etru	cter	e bul	mone		Intervel Between Onset end Deeth
		e	resulting in dealing		Due to (or es				e pul	dis	20	0
pelm	d msit	Examiner	Sequentially list conditions	b	Due to (or es	e consequ	ence of).					
4	1		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events		Duo 10 (01 03	o consequ	onoc ory.					
tifficate be	physical s the bu	edicai	Ceuse (Disease or Injury that initieted events resulting in death) Lest	C	Due to (or es	e consequ	enca of):				-	
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death ce	for us	Physician/N		<u> </u>								
) å	y the	ysic	Pert II. Other significant conditions of	ontributing to death bu	it not resulting	in the un	derlying cause giv	en in Pert I.		_		the cause of death?
thet	ned b	by Pt	osteop	rofe	9				142	¶es 2□ No	3 Prob	ably 4 Unknown
law requires	s been signed by the ettending should be deteched for use	Completed b	V						24a. Wes	en eutopsy ormed?	eve	re eutopsy findings ilable prior to apletion of cause eeth?
The la	te ha	шо							10	Yes 2 No		Yes 2□ No
cian: T	ortifica ctor, p	BeC	25. Was case referred to medical exeminer?					26. Plece of D	eeth (Check only	one)		
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Ing P	After t funera	ion:	27. Menner of Death 1 TNaturel 5 ☐ Pending	28e. Dete of Injur (Month, De)	Year) 28b	. Time of Injury	28c. Injur Wor		28d. Describe	how injury occur	ed	
or Attending efter death.	y the	licat	2 Accident investigation 3 Suicide 6 Could not be		iny - At home	farm stre		Yes 2□No	28f Location /	Street end Numb	er or Rural	Route Number
a se se se se se se se se se se se se se	Dire d in b	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	iam, sto	st, lactory, onice		City or To		gi oi ribiai	riobto ridinos,
Hospita 24 hours	To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Example 1	yelclan: To the best of liner: On the besis of end manner sta	examination e	ge, deeth end/or inve	occurred et the tirestigation, in my o	ne, date end pleo pinion, deeth occ	ce, end due to the curred et the time,	ceuse(s) end me dete end plece,	nner as ste	ated. the ceuse(s)
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1	V		30. Neme end eddress of person who	completed cause of de	eeth (Item 23e		rint) D	PO-15	in Re	1 # 1	08-	
			TAHOORA F	THWHJ	4	177	Ba	Item	ne 1	4D 2	120	18
	Sta Registr		31. Dete filed (Month, Day, Year)	Su Registra	r's Signeture	Boyde Co	2					

200 1-25-98

DECENSED - KATHELINE SEAMAN



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Physic /Medi			RALPH	STAT					Januar		98	245 An
Exami				e street and number)				4b. City, Town, o				
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No ma		10a. State	10b. County		10c. City	Town or Loc	cation				10d.	Inside City Llm
ms 23s or 28s-f show	to	MARYLAND	N/A			BALTI	MORE C	ITY			>	Yes 2
2 28 P	rec	10e. Street end Nu	mber	Hall bear			10f. Zip Co	de		10g. Citizen of W	het Country?	?
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or its	by Funeral Director	11. Maritai Status 1 ☐ Never Man 3 ☐ Widowed	ied Married 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:	Ever in U,S	5. 13. V	Ves Decedent Yes, specify	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or forto Rican, etc.)	No- 14. Race Bieck Specify:	e - American I k, White, etc. BLACI	
"natural".	ted	/Sne	15. Decedent's E	ducation		16e. Deced	ent's Usual O	ccupation one during most of watered)	rorking	16b. Kind of Bu	siness/Indust	try
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al Hygie I other vent, it	Be C	17. Father's Name	(First, Middle, Last					18. Mother's N	ame (First, Midd	le, Meiden Sumem	9)	
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nysician		23a. Part1. Enter t shock, or hea	he disease, or com rt failure. List only	plicetions thet caused one cause on each li	the deeth. ne.	Do not ente	er the mode of	dying, such es cardi	ac or respiretory	errest,	Int	proximete ervel Between set end Deeth
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attanding phi I for use as th		resulting in death)	Last	d								
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 5 per FH G-756 2/6/98 dh Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** SHOMPER January 22, 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner

3. Time of Death 10:45 PM Franklin Square Hospital Center Rosedale Baltimore Birthplace (State or Foreign Country) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 202-10-2746 10XM 2□ F Months Days Hours 93 Feb. 22,1904 Director Pennsylvania Usuet Residence of Decadent the Merylend ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10e Stete 10b County 10c. City. Town or Location 10d Inside City Limits Middle River 1 Yes 2X No Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 United States 1007 Orems Road Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours efter of Hygiene. other then "natural", or ite 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: by 3 Midowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Bustness/Industry Etementary/Secondary (0-12) College (1-4or 5+) 5 Years Carpenter Carpentry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) parmit. Peges 1 and 2 should be filk Department of Heelth and Mentel Hy Important: If Item 27 is marked oth any linjury or other traumatic event Pates. Gussie Unknown Daniel Shomper 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Orems Road Baltimore, Maryland 21220 Jean R. Shomper/Daughter in law 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Schuylkill Mem. Cemetery 1/27/98 Schuylkill Haven, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Coens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. nexy 7922 Wise Ave. Dundalk, Maryland Do not enter the mode of dying, such es cardiac or respiratory errest, 23a. Part 1. Enter the disease, or conplicetions that caused in a Approximete Interval Between Onset and Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical 4 Days a Respiratory Failure **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Pneumonia Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): P.O. Box 68760 The law requires that the death certificate be Due to (or es e consequença of): signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia, Parkinson's Disease, Hypertension Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peen Glaucoma, Renal Failure pege 2 s certificate 1□ Yes 1 Yes 2 No After this certifical funeral director. or Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 10 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending efter deeth.

Director: Aft
d in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and manner stated. edical 29a, Certifier (Check only within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Dete filed (Month, Day, Year) JAN 27 1998

Satpal Dang MD.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

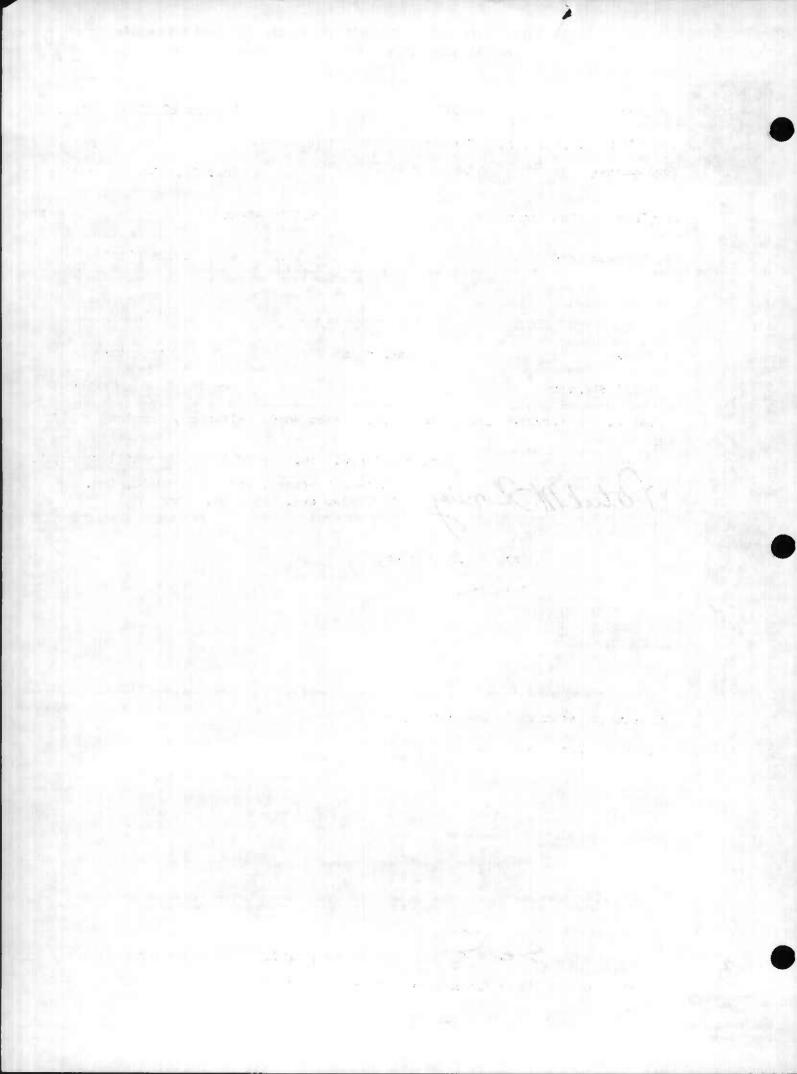
32, Registrar's Signature hus Davidson Francisco

9000 Franklin Square Dr.

1/1202

Balto, Md. 21237

January 23, 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JANUARY 23, 1998 6:15 AM Elizabeth Storke Mary /Medical 4c. County of Deeth
Baltimore 4e Eaclity Name (If not institution, give street end number) Saint Joseph Medical Center 4b. City, Town, or Location of Deeth Examiner 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign
Country) **Funeral** 1 M 2 KF 89 Yrs. 221-09-8416 Director February 22, 1908 Deleware Usuel Rasidenca of Dacedeni the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be nothled at 1 XYes 2 No Baltimore Director Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3411 East Northern Parkway 21206 United States daath Funeral Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Pages 1 and 2 should be filed within 72 hours effer ann of Health and Mantal Hygiene. It if them 27 Is marked other than "natural", or ite ity or other traumatic event, the Medical Experies 1 ☐ Yes 2 💢 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Ella Jarrell Harry Hufnal 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19709 Middletown, DE 206 South Cass Street Mrs. Susan Reynolds / Niece 20b. Placa of Disposition (Neme of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: if any Injury or page. 1/27/98 4 ☐ Donetion 5 ☐ Othar (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signeture of Funeral Service Licensee Mark T. Zavoyna 22. Name end Address of Fecility Leonard J. Ruck, Inc. Zavogre Mai 5305 Harford Road Baltimore, Md. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximete Intervel Between Onsat end Death **Physician** RIGHT LOWER LOBE PNEUMONIA /Medical Immadiate Ceusa (Finel diseesa or condition resulting in deeth) DAYS Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, if eny, laading to immediate ceusa. Entar Underlying Ceuse (Disease or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of): Physician/Medicai Due to (or es e consequence of): USB signed by tha a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANEMTA þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed CHRONIC ATRIAL FIBRILLATION page 2 hes 1 ☐ Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No this funaral 27. Magner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Aftar Attending 1 Natural 5 Pending efter daath. Director: Aft 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, straat, fectory, offica building, etc. (Specify) 4 Homicide Hospital or A
 Z4 hours efter
 Funeral Directletaly filled in b edicai 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Cartifiar completaly (Check only one) To the To the To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) anda P mella D 41410 M.D 30. Name end address of person who complated causa of daath (Item 23e) (Type, Print) JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Dey, Year)

JAN 27 1998

32. Ragistrar's Signature

Maryland 21215-0020

Baltimore.

Division of Vital Records.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Walter Barclay Swem, Jr. 26, 1998 8:00 AM January /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harborside Health Care - Harford Gardens Baltimore N/A If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
March 17,1917 7. Age (In yrs. last birthday) 5. Social Security Numbar 6. Sax Birthpiaca (State or Foreign Country) **Funeral** Days Months 1**X**) M 2□ F Director 80 Maryland 215-01-2371 Usual Residenca of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits "naturel", or Items 23a or 28a-f show ideal Examiner must be notified at 1 X Yes 2 □ No Funeral Director Maryland N/A Baltimore 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? 21239 United States 5652 Woodmont Avenue Apt. B death 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours efter 1 ☐ Never Married 2X Married 1 X Yes 2 □ No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Policeman Law Enforcement Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be nent of Health and Mental P Elizabeth Moorman Walter Barclay Swem, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2: Department of Health at Important: If item 27 is eny injury or other tra Balto., MD 21214 5652 Woodmont Avenue Apt. B Theresa C. Swem / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 1/29/98 Baltimore, Maryland 21. Signature of Funeral Service Licensee Timothy S. Harman 22. Name and Address of Facili Leonard J. Ruck Funeral Home, Inc. Haure 5305 Harford Road Baltimore, MD 21214 23a. Part1. Entar the disease, of complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heer failure. Lief only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) with /Medical Probable Carrimona (() Examiner Due to (or as a consequence of): Physician/Medical Examiner mets Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Diseasa or injury that Initiated events resulting in death) Lest pur Due to (or as a consequence of): Cerebravasarlan Box 68760. Dua to (or as a consequence of): harmorrhape mels Hypertinsun Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown The law requires that à Records, aign 24b. Were autopsy findings available prior to completion of cause of daath? pege 2 should Completed 24e. Wes en eutopsy performed? 1 Ves 2 TLAK 1 Ves 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifica etely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner es steted.
2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

821 N. EUTAW St Smite 308, Balt. MD HASHMI. Za Regional's Signature Liver Devidson—Aandall

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

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29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month ROSE SHUR 23 TAN 1998 9:10 AM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth LEVINDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 XF 217-32-7933 97 OCT.15,1900 RUSSIA Usual Residence of Decedent 10c. City. Town or Location 10e. Stete 10b. County 10d. Inside City Limits BALTIMORE N/A 1 ¥ Yes 2 □ No 10g. Citizen of Whel Country? 10e. Street and Number 10f. Zip Code 2500 W. BELVEDERE AVE, APT. 219 21215 USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ X9o Specify: Specify: WHITE 3 □XVidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MEYER TRAUB ANNA WARANCH 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 37 PENNY LANE MRS. RHODA GETZ (DAUG.) BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate tX Burial 2 ☐ Cremetion 3 ☐ Removel from Slale ADATH YESHURUN CONG. 1/26/98 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility BROS., INC. ruser 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset end Death Immediale Ceuse (Final INROSEPSIS Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown LEUKENIA, ATRIAL FIB 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes →No

Physician /Wedical Examiner

Physician

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Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If flem 27 is marked othe eny injury or other traumatic event, page.

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Division of Vital Records, P.O. Box 68760.

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25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1) Ratural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier Modlas

29c. License number

29d. Date signed (Month, Day, Year)

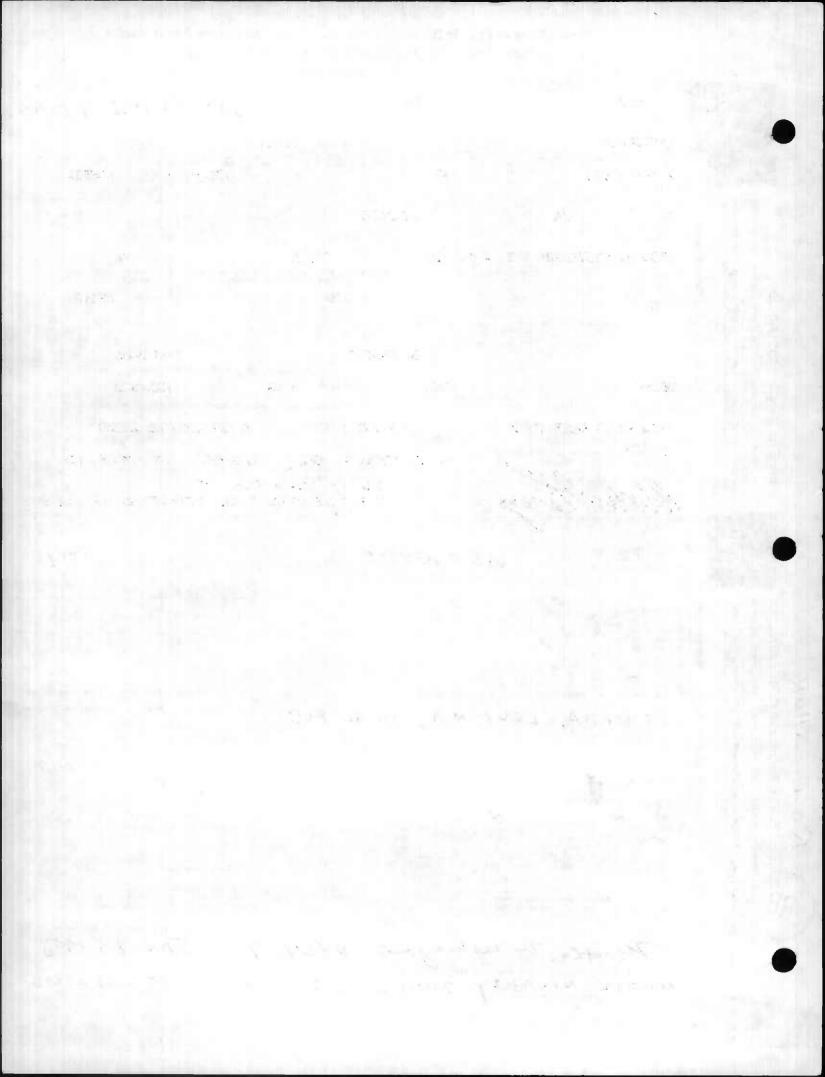
Bervedere Balt, no 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINABNEY MATTHEN 31. Date filed (Month, Day, Year)

32. Registrar's Signature Fulia Davidson Randalla

2434



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jan. 2 Pay SCHISLER 1998 CHARLES B . 2:00am /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Deaton Nursing Center Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. Director 218-18-3823 74 May 6, 1923 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Md. Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Virginia Ave. 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, e filed within 72 hours after tal Hygiene. Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 Ves 2 No If Yes, Give 1□ Yes & No White à 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Machinist 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill hand Mental H Charles Schisler Mabel Pillsberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Itam 27 Is any injury or other trau Inez Schisler / wife 705 Virginia Ave. Baltimore Md. 21221 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Sacred Heart of Mary 1/26/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the death. De not enter the mode of typing, such as certain or respiratory errest, 21221 shock, or heart failure. List only are cause on each are. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final hecol closed and ra191197 disease or condition resulting in death) Examiner Due to (or as a consequence of): complicated b Frantire 11 Ceptical spine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Myocorrellal inforction NIS MINNES Physician/Medical Due to (or es e consequence of) 80 hoomst disease Hyperkensive 545 Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? Corcline amythomias 1 | Yes 2 No 3 | Probably 4 | Unknown Rhaumatural anthritis à 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel supportell att ladder 1 Yes 2 No Unknown M 2 Accident 12-21-97 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 705 VIR CINIA AVENUE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 - Homleide To the Hospital o within 24 hours aff To the Funeral DI completely filled in Jone

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Baltimore, Maryland 21215-0020

BALTIMORE MARKAND 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier 20

31. Date filed (Month, Day, Year)

JAN 27 1998

29a. Certifier

29c. License number 030494 29d. Date signed (Month, Dey, Year) 1/22/98

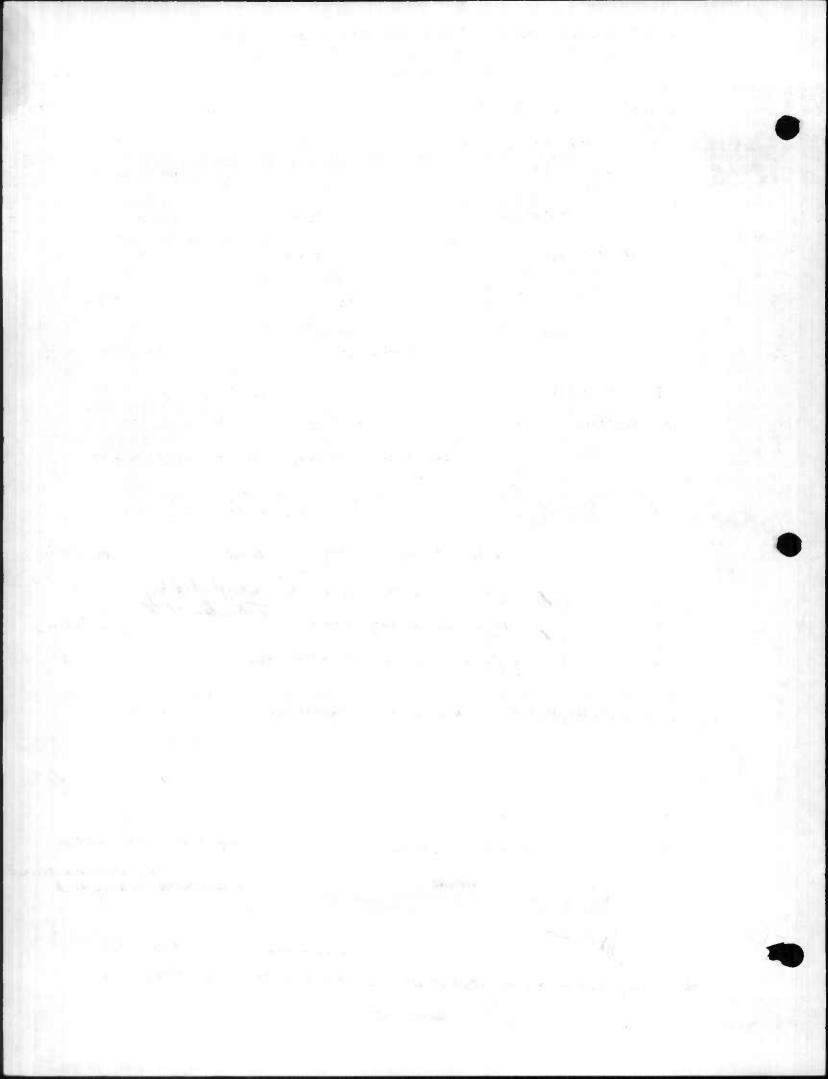
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

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Division of Vital Records, P.O. Box 68760,

State Registrar

Medical Certif

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31. Data filed (Month, Day, Yaar)

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32. Registrar's Signatura

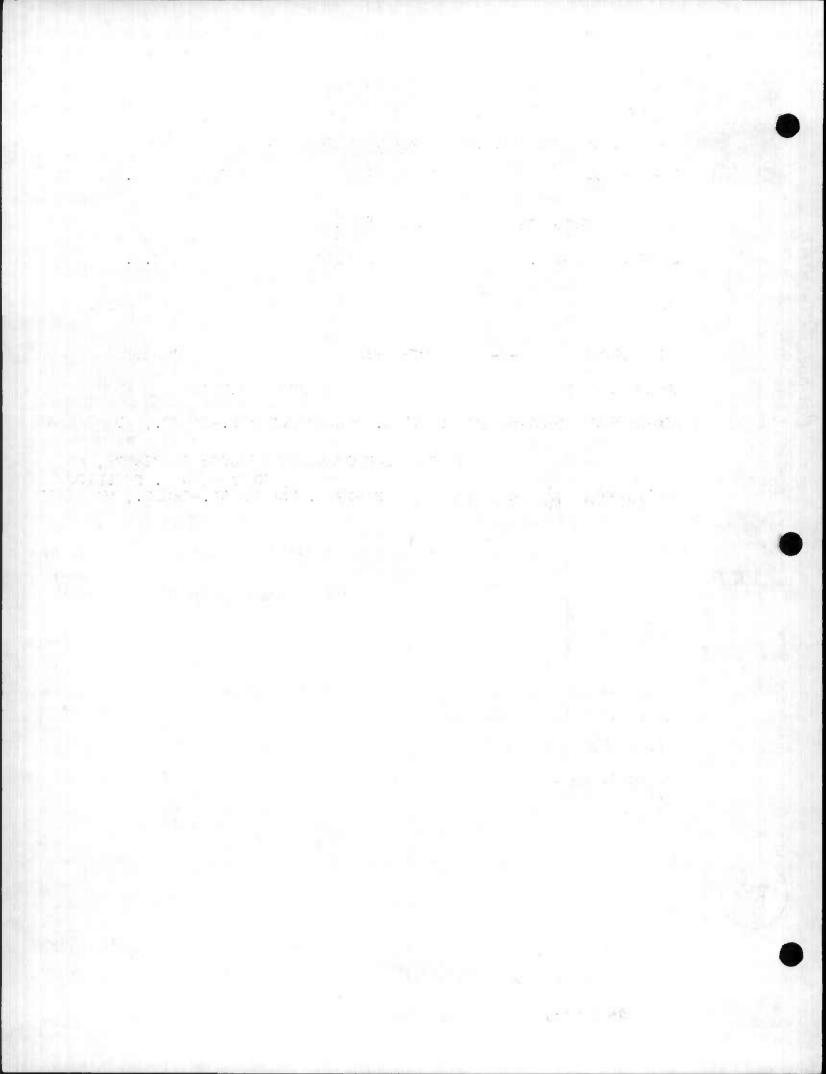
30. Nema and address of person who completed cause of deeth (Itam 23a) (Type, Print)

RETHA RAJA 4367 Holling Fenry Rd Julia Tavidson-Randall

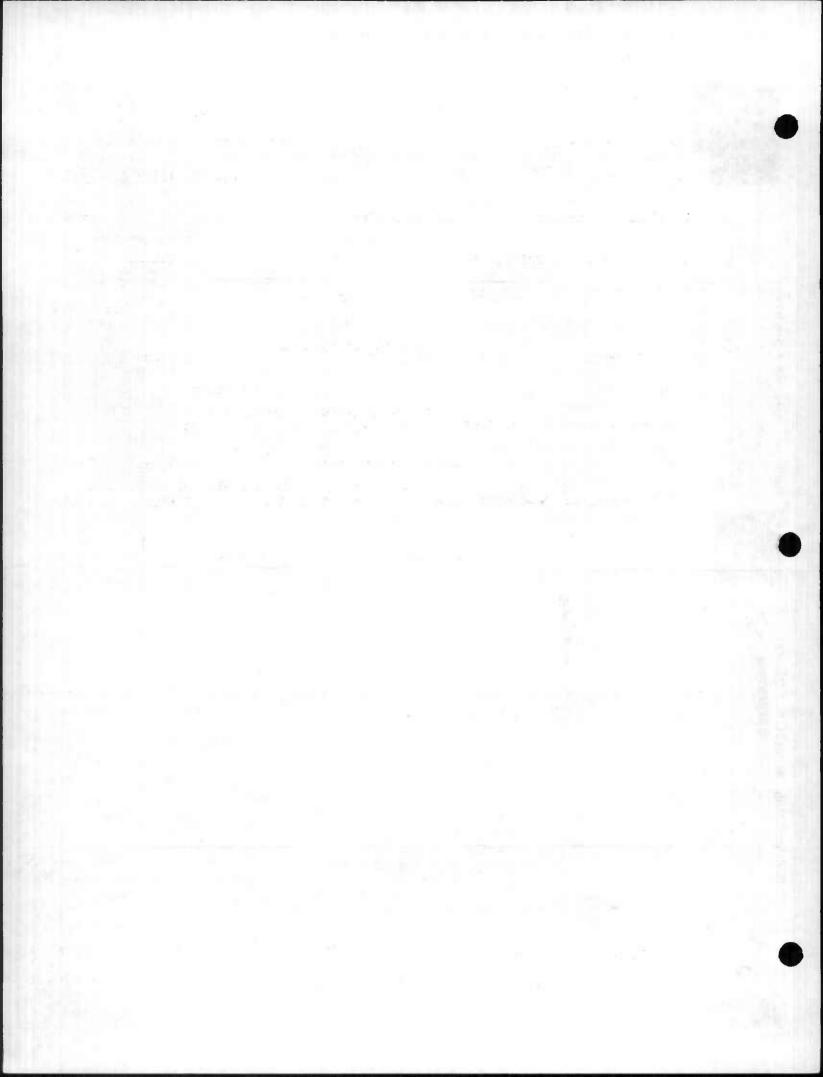
1 Cartifying Phyalclan: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

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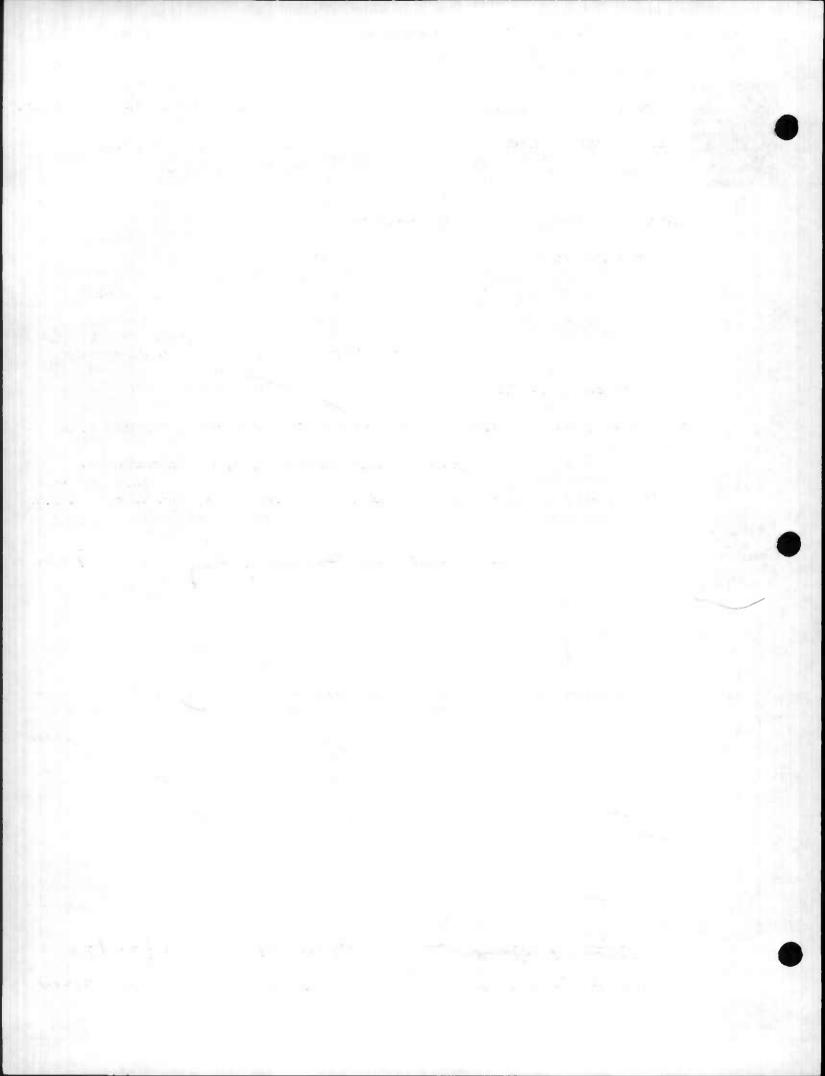


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State of Maryland / Department of Health and Mental Hygiene

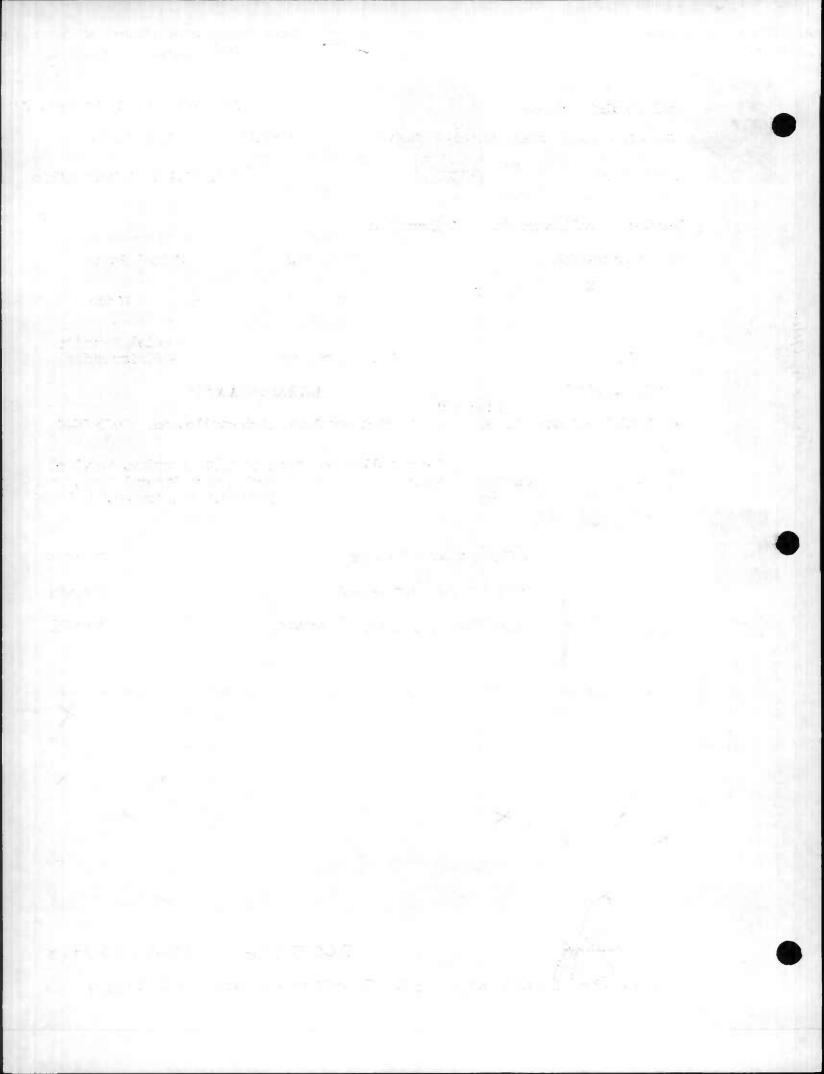
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 0 1 Q 1, 5

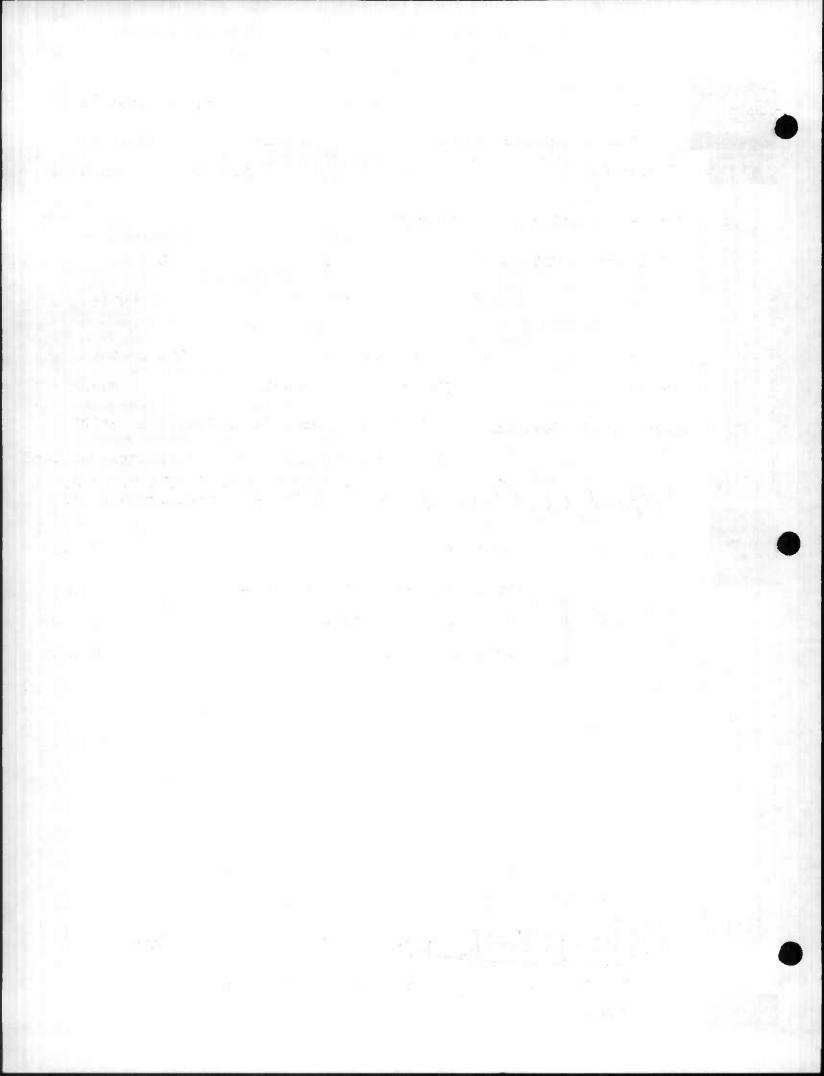
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tor:	2 ☐ Accident 3 ☐ Suicide	investigation		-61.1		М		es 2 No	0011				
ai Director: After tiled in by the funera Certification:	4 Homicide determined 28e. Placa of Injury - At home, farm, street, fa building, etc. (Specify)							, factory, office 28f. Location City or			lumber or Hu	urel Route Number,	
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Ne Me	29b. Signature end	title of centure				29c.	License	number	T	29d. Date s	igned (Mont	h, Dey, Yeer)	
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3	30. Neme and eddre	es of person who	completed caus	e of deeth (Item	n 23a) (Tvoe	Print)		5 5.6:	77	7,000	AUY C	5,1998	

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State of Maryland / Department of Health and Mental Hygiene	8	-0	8	1	0

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** Jahuary 22 1998 10:20PM Margaret Н. Trent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Centers Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country)
Maryland **Funeral** 10 M 30 F Months 217-34-3068 83 14 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Experient must be notified at 1 ☐ Yes 2 € No Directo Maryland Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7232 German Hill 21222 Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Aq Specify: White 3 Widowed 4 □ Divorced "naturai", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed withir Department of Haalth and Mental Hygiana. Important: If Itam 27 is marked other than any injury or other traumatic event Etementary/Secondery (0-12) Cotlege (1-4or 5+) 2 NA Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams Ernst Pearl Beach 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11 Lelf Aileron St. Balto., Md. 21220 Agnes B. Day (Daughter) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 26 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Balto. Nat. January 22. Name and Address of Facility ski-Chojnacki F.H.P.A. 21. Signature of Funeral Service Licenser 1005 Dundalk Ave. Baltimore, Md. 21224 as nach 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) Carcinoma of Lung /Medical 3 years Examiner Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease 12 years that the death certificate be executed physician end s the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Malignant Melanoma left Eve 3 years Box 68760 Physician/Medical Due to (or es e consequence of): Essential Hypertension ettanding p 10 years Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? the signed by the 187 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peed has 1□ Yes 21 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2√2 No funaral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 10 4 Thomicide 29a. Certifier Medicai 🖎 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and tile of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 D14160 01/23/98 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 5410-A Ritchie Hwy. Baltimore, Md. 21225 Harijit Singh M.D. 32. Registrar's Signature Dey, Year) State JAN 27 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Bart almadge 2:26pm January 21 /Medical 4a. Facility Name (If not institution, give street end humber, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Northwest Randallstown Hospital Center Baltimore 5. Social Security Number if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Deys September 22,1961 Baltimore City, Md. 1₩ M 2□ F Months Hours Min 219-84-2511 36 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Musical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21207 4007 Brookhill Road USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🗶 No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter nent of Heelith and Mental Hygiene. It is the TS Is marked other then "natural; or ite iny or other treumatic event, the Mental Experient iny or other treumatic event, the Mental Experient. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify P 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Providence Bank Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 20 Benjamin Talmadae Anna Fink 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 C Revere Court Baltimore, Maryland 21234 Glen R. Talmadge (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery January 24, 1998 Baltimore, Maryland 21. Signature of Funeral Service Licensae 22. Name and Address of Facility Lassahn Funeral Home, Inc. Choico K. 7401 Belair Rd. Baltimore, Maryland 21236-4625 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physiclan** /Medical Immediate Cause (Final LYMPOHOMA HODGKINI diseasa or condition rasulting in death) TEARS Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consaquence of). Box 68760 Physician/Medicai Due to (or as a consequence of): Records. P.O. Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dfd tobacco use contribute to the cause of deeth? the signed by the 1 Yes 2 No 3 Probably 4 ∭Unknown by 24b. Ware autopsy findings aveilable prior to completion of ceuse of deeth? Completed 24a. Was an autopsy peen hes page 2 certificate 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa referred to medical examiner? Be 26. Placa of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ◯ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred efter deeth. 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 MNatural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) illed in by 4 Homicide the Hospital within 24 hours to certifying Phyalcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifier Medical (Check only one)

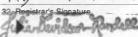
State Registrar

SYED

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) Astreuf C/O NORTH WEST HOSPITAL CENTRE MO

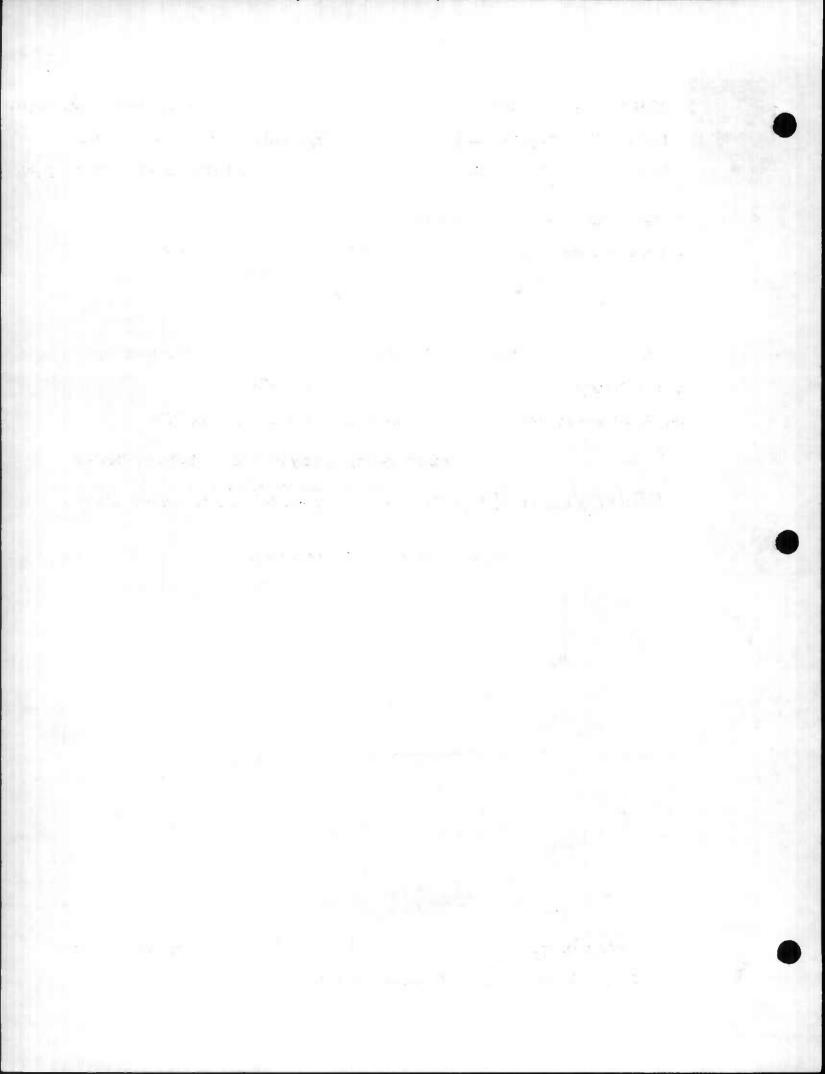
31. Date filed (Month, Day, Year)

29b. Signature end title of certifier



29c. License number

29d. Date signed (Month, Day, Year) JANUARY 81, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** JOHN JANUARY 23, 1998 Williams 3:25 /Medical 4c. County of Death 4e. Fecility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death Examiner BALTIMETE
II Undar 24 Hrs. 8. Deta of Birth
Min. Month, Day, Year) City MARYland GENERAL 7. Age (In yrs. last/birthday) If I If Under 1 Yaar 5. Social Sacurity Number Bighplaca (Stata or Foreign Gountry) **Funeral** 10M 20 F Months Days 213-18-5780 Director Mo line Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Llmits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Tas 2 No Director Hary Ino 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of What Country? Bloom 21217 USA 507 Funeral Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: Black Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Businass/Industry Unites States permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Itam 27 la marked other than any Injury or other traumetin. Elamantary/Sacondary (0-12) Collega (1-4or 5+) 4th grade WAYEKIUSEMAN 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be ROSA LEE William 1URNAGE 2 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, Stata, Zip Code) Bloom Street Method of Disposition
19 Burial 2 Cramation 3 Removel from Stata Boltinor, Hd 2/2/7 RALdine 20c. Location - City or Town, Stata 20b. Placa of Disposition (Name of camatary, cramatory or other place) M Forest Veterowillya. Uw.
22. Nema and Address of Facility CHATMAN-4 Donation 5 DOthar (Specify) 21. Signature of Funeral Service Liderisee 23e. Part Entar the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batwe Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition resulting in daeth) PSEUdomoras /Medical Examiner Physician/Medical Examiner Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Lest Aand P.O. Box 68760. Dua to (or as a consequance of): ettending | for use as HRtery DISEASE signed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Wara autopsy findings available prior to complation of causa of deeth? 24a. Was an autopsy performad? page 2 s 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Deeth 28b. Tima of 28d. Dascribe how Injury occurred Medical Certification: 5 Panding invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 281. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) á 4 Homicida To the Hospital within 24 hours after To the Funeral Dir Certifying Physictan: To tha best of my knowledge, death occurred et tha tima, date end placa, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated. 29a. Cartifier 29b. Signature and title of conflie 29c. Licansa number

who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year)

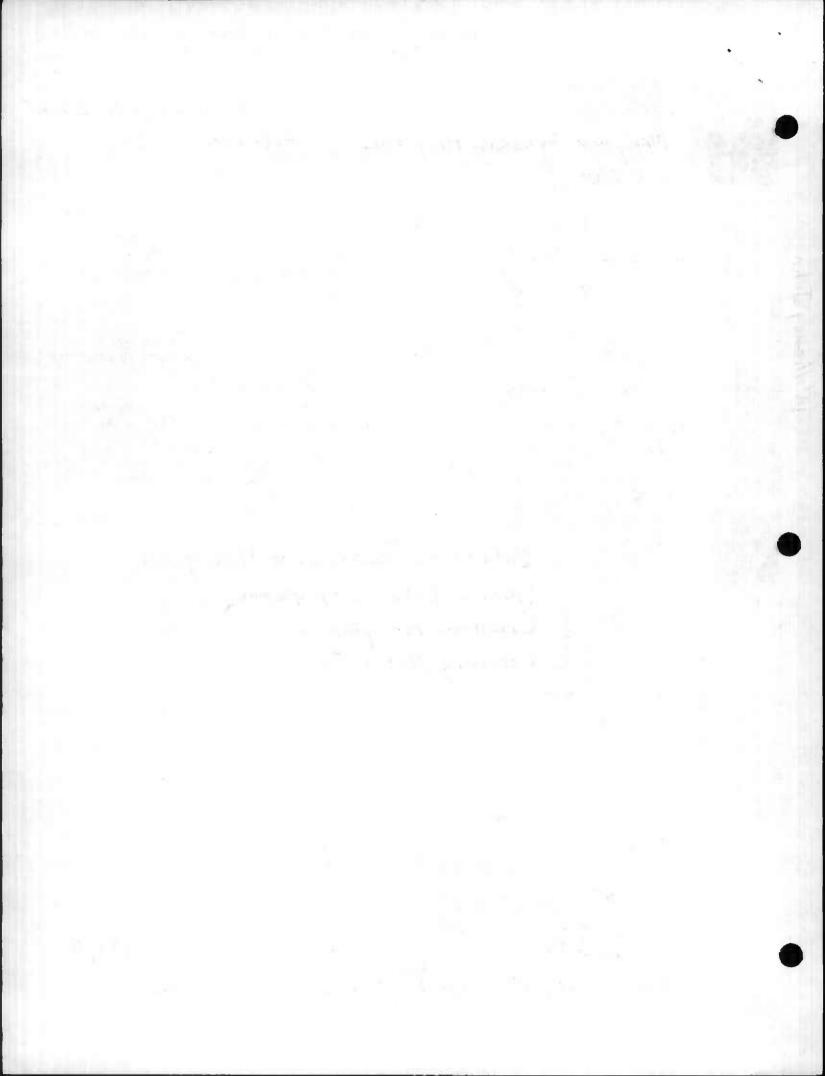
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MARYland GENERAL HOSPITAL

29d. Date signed (Month, Dey, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ay th **Physician** Month Walker Kenneth Anvary 30pm /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MEDICAL BOHIHORE LIBERTY Center If Under 24 Hrs. B. Date of Birth Hours Min. Month Day 6. Sex 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country), **Funeral** Days 218-76-8276 Usual Residence of Decedent Yrs. Director Mary/ones 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at HOYes 2□No Director BALTIMORE Mary Isos 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Precetmon Street 1424 pemil. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Menle! Hygiene. Important: If itam 27 ie marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. USA 2/2/ Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. Never Married 2☐ Married 1 Yes 2₽No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) irate ABOIET 95cdE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WAlken KENNETH Smith GLADYS 19a. Informent's Name/Relationship (Type, Ppint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helley KENNETh Smith SHEEF BALTINUR, 2201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State -30 Memorial Gargas 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility CHA Part Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, above, or head failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physiclan /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner alcohol ABuse Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Liver Failure Physician/Medical Due to (or as a consequence of): paso Part It. Other eigniftcant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 ☐ Yes 2 ☐ No Acidorio signed b by 24b. Were autopsy findings available prior to completion of cause of death? Completed Hepatic Encephalopathic 24a. Was an autopsy performed? 1□Yes 2□No certificate 1 Yes 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 22 No Medical Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

P.O. Box 68760 Records, Division of Vital Hospital or Attending Physician: 24 hours effer deeth. Funaral Director: After this certifics stely filled in by the funerel director, i To the Hospital within 24 hours e To the Funaral Completely filled

the Merylend

Baltimore, Maryland 21215-0020

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier

JAN 27 1998

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year) Muany

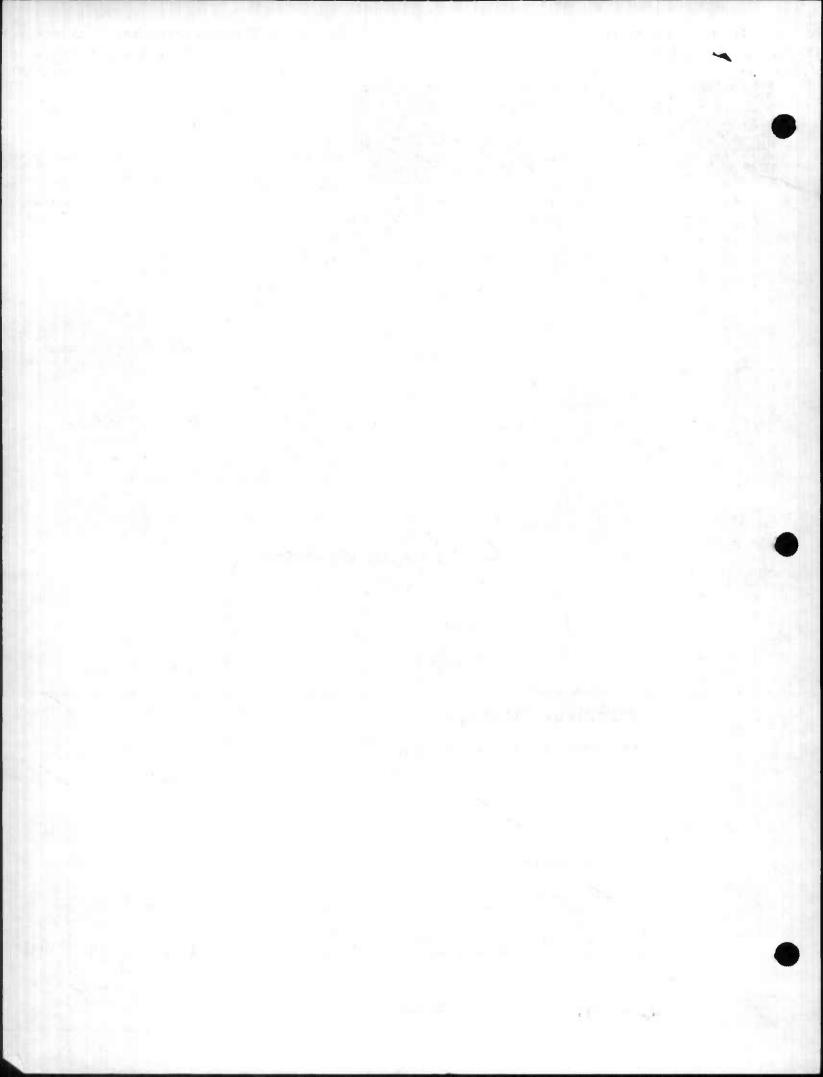
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Libert Terance L. LAMB 31. Date filed (Month, Day, Year)

nedical Center

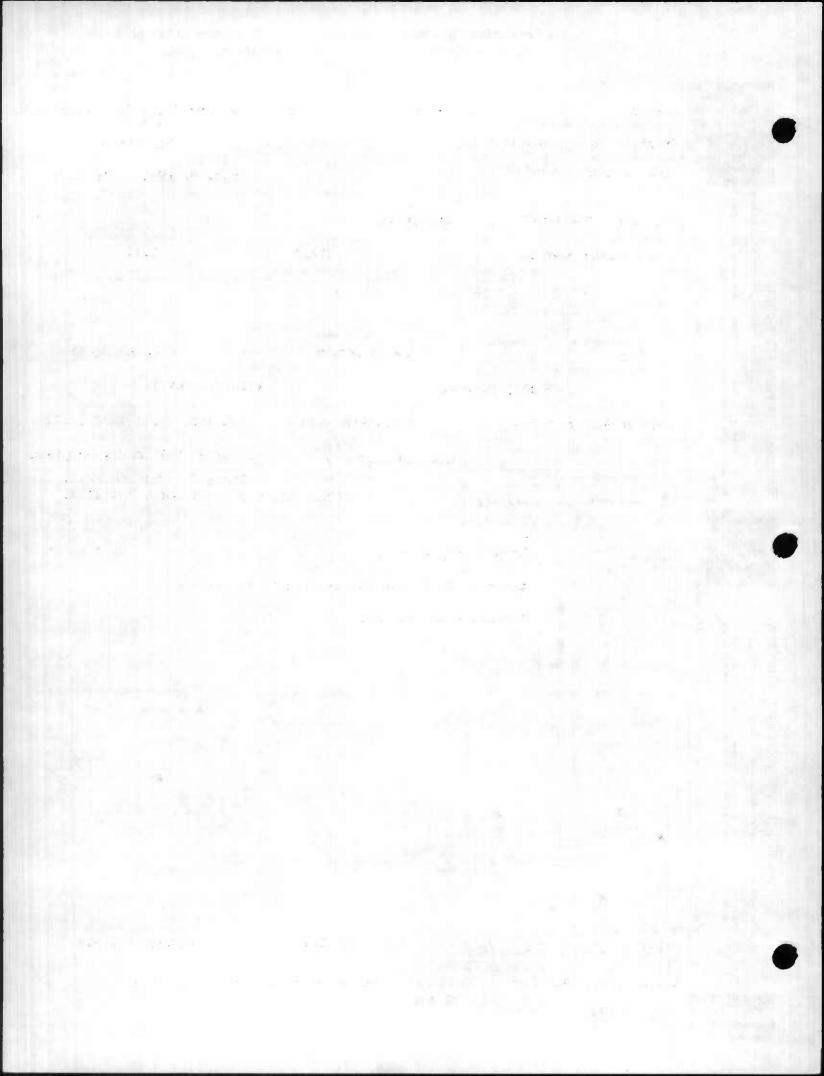
State Registrar 32. Registrar's Signature

am



State of Maryland / Department of Health and Mental Hygiene

			State of Marylar		ate of Death		Reg. No.9 8	01850							
		1. Decedent's Name (First, Middle, La	st)			2. Dete of Dee		3. Time of Death							
	Physician /Medical	Herman	Alexan	der	WEST	January	01 1000	12:58 A.M.							
	Examiner	de Englis. Name (Mant Institution six			4b. City, Town, o	or Location of Deeth									
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	Funeral Director	210 30 2292	6ex 7. Age (In yrs. 18€ M 2□ F 56	. lest birthday) If U Yrs. Mon	nder 1 Year If Under 24 H Ihs Deys Hours Mi		y, Year) 9. E	Birthplace (Stete or Foreign Country) Maryland							
	pus }_	Usuel Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits							
	f sho	Maryland Baltim	ore B	altimore				1 ☐ Yes 2 🕱 No							
	or 28a-f s	10e. Street and Number			. Zip Code		10g. Citizen of Whet	Country?							
	h with		iue		21222		U.S.								
020	72 hours after death with the Manyland neturel; or items 23a or 28a-f show deal Evanine must be notified a steed by Funeral Director	3 ☐ Widowed 4 ☐ Divorcad	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		ecedent of Hispanic Origin? specify Cuban, Mexican, Pures 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. White							
Maryland 21215-0020	ed within 72 ho bygiena. Fr than "nature ft, the Westerl Completed	15. Decedent's Ec (Specify only highest green Elementery/Secondary (0-12)		(Give kind o	Usuel Occupetion f work done during most of w T use retired)	vorking	16b. Kind of Busines								
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Z	17 Is	Jeanne West / wi			sta Avenue		ore, Maryl								
ē,	- I = 6	20e. Method of Disposition	20b.	Pleca of Disposition cametery, cremetory		Dete	20c. Location - City								
E O	Pages nent of I int: If its iry or o		Hemovel from State			1/26/98	Baltimore	e, Maryland							
Baltimore,	permit. Pages Department of Important: If I any Injury or price.	1 Signeture of Funeral Servica Licensee 21. Signeture of Funeral Servica Licensee 22. Name and Address of Facility 23. Name and Address of Facility 4001 Ritchie Highway Baltimore, Md. 21225													
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A	/Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	Respiratory					1 month							
L	sit sit		Squamous Cell Lung Cancer with Liver Metastasis												
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ta	certificata rector, pag	25. Wes case referred to medical			26. Place of D	Deeth (Check only o									
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	ding Ph. After th funeral		28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	how Injury occurred								
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After tecmpletaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not b	9 Ogo Plans of Joins, At h	nome, farm, street, fa ify)	actory, office	28f. Location (: City or To	Street end Number or vn, Stete)	Rural Route Number,							
	Hospi 4 hou Funer taly fill														
	within 2 To the comple	29b. Signeture end title of cartifier													
		Dr. Suzette	Charolle		RD 02115	J	January 24	,1998							
	6	30. Neme end eddress of person who			-	1	10 0100 T								
	~	Dr. Suzetter Char			uare Drive Ba	Itimore,	MD 21237								
1	State	31. Dete filed (Month, Day, Year)	Julia Bull distrar's Rom	larence											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth January 22, 1998 MARY ELIZABETH WINKLES 5:01am 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 3615 Fels Lane Ellicott City Howard County H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1992 1992 1992 5. Sociel Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 1□ M 2√5 213-26-8049 69 Yrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard County Ellicott City 1 ☐ Yes 2 No 10e. Street end Number 3615 Fels Lane 10f. Zip Code 10g. Citizen of What Country? 21043 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Never Married 3 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unknown own home homemaker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Martha E. Crider Walter T. Cavey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Winkles, Sr./spouse 3615 Fels Lane, Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, cremetery or other place) Good Shepherd Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete XXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete **26JAN98** Ellicott City, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sch Sis Due to (or es e consequence of): uleens Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellit15 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of injury

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) end manner as steted.

| Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end piace, and due to the cause(s) end manner steted.

29c. License number

1 Yes 2 No

D34195

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

January 22, 1998

Examiner physician and is the burier ransit attending for use as

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

with the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mantal Hygiana. Important: if Item 27 is marked other than "natural". or Many Injury or other traumetic event.

been signed by should be datac

Examiner Physician/Medical þ Completed Be P Certification:

Aftar this cartificata has funaral i or Attending after death. I Director: Aft d in by the fur filled in by Hospital 24 hours a Funeral D complataly

Division of Vital Records, P.O. Box 68760,

To the Vithin 2

31. Dete filed (Month, Dey, Year) State Registrar

1 Anaturel

2 ☐ Accident

3 ☐ Suicide

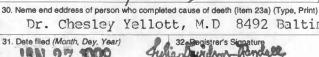
29a. Certifier (Check only one)

Medical

4 Homicide

5 Pending Investigation

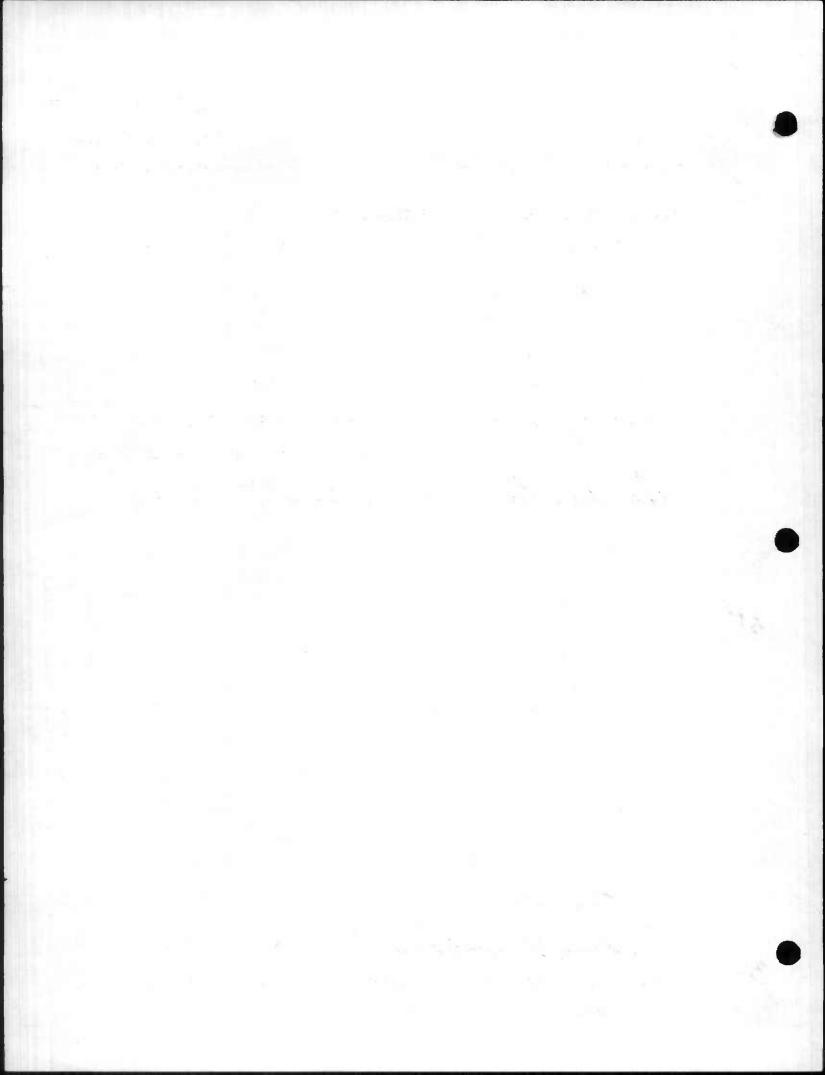
6 Could not be determined



resley W. hellat mo.

Dr. Chesley Yellott, M.D 8492 Baltimore Nat'l Pk., Ellicott City, MD 21042 32 Degistrer's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 1852

					Certificate	of Death		Reg. No.	0.00		
Physic	ian	Decedent's Neme (First, Middle, La	No.				2. Dete of De Month	Dev	Yaer 1990 14: 40		
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Funeral		Sociel Security Number 6. S		a (In yrs. last birt	hdey) If Under 1	Yaar If Undar 24 Hr	s. 8. Data of Bi	,	Birthpieca (Stete or Foreign Country)		
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and w		Usuel Residence of Decedent 10a. Stata 10b. County		10c. City, Towr	or Location			10d. Inside City L			
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r 28a	Director	MD Baltimor 10e. Street and Number	e	Timoni	10f. Zip 0	Code		10g. Citizen of V	Whet Country?		
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aftar daal or items	Funeral	11. Marital Stetus	12. Was Decedent Armed Forces?		13. Was Decede	int of Hispenic Origin? (y Cuben, Mexican, Pue	Specify Yas or No	o- 14. Rac	e - American Indian, ck, White, etc.		
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D = - =		Paul Wilkinson -				er Court, T			, , , , , , , , , , , , , , , , , , , ,		
of Ham Itam		20a. Method of Disposition		20b. Piaca of	Disposition (Name y, cremetory or oth	of .	Dete		City or Town, State		
Page mant ant: If ury or		1 X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetlon 5 ☐ Othar (Spacify		Baltimo	re. MD						
permit. Pages 1 an Department of Haal Important: if Itam 2 any injury or other once.		21. Signature of Funeral Service Licer	1688		Park Cen	Address of FecilityLo	udon Par	k Funera	al Home		
20113		Durny. 4	nh			36	20 Wilke	ns Avenu MD 212	ie .		
Physician		23a. Part1. Enter the disease, or con- shock, or heart failure. List body	plications thet caused one ceuse on each li	I tha daath. Do n	ot enter the mode	of dylng, such as cardi	ac or respiretory e	errast,	Approximeta Intervel Between Onsat and Deeth		
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Examiner	_	resulting in deeth)	6.	Due to (or es e o	onsequenca ot):						
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s that the	by Phy						1 🗆	1 ☐ Yes 2 ☑ No 3 ☐ Probably			
To the Hospital or Attending Physicien: Tha law requires that the death cart within 24 hours after death. To the Funerel Director: After this cartificate hes been signed by the attending completely filled in by the funeral director, page 2 should be datached for use.	Completed b							en eutopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of deeth?		
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ath. r: Aftar he funar	atlon	1 Neturel 5 Pending investigation			ime of 280 jury M	c. Injury et Work? 1 Yes 2 No	26d. Describe	how injury occur	ed		
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10		30. Name and address of person who	completed cause of d	eath (Item 23e) (Type, Print)	90P 900					
Sta	ate	31. Deta filed (Month, Dey, Yeer)	32. Registra	ar's Signeture	TOMES	TO 7 1. 300					
Regist		JAN 27 1998	grian	Signeture Davidson-M	andelle						

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NAME: WILL

Physician /Medical Examiner **Funeral** Director

ortant: If item 27 is marked other than "neturel", or items 23e or 28e-f show injury or other traumstic event, the Medical Examinat must be notified at Important: If item 27 is marked other than eny injury or other traumatic event, the Me Hygiene. 2 should be fi Pages 1 end 2 should nent of Health end Men

Physician /Medical Examiner

signed by the ette peeu has

Division of Vital Records, P.O. Box 68760 this certificete To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific filled in by the

> State Registrar

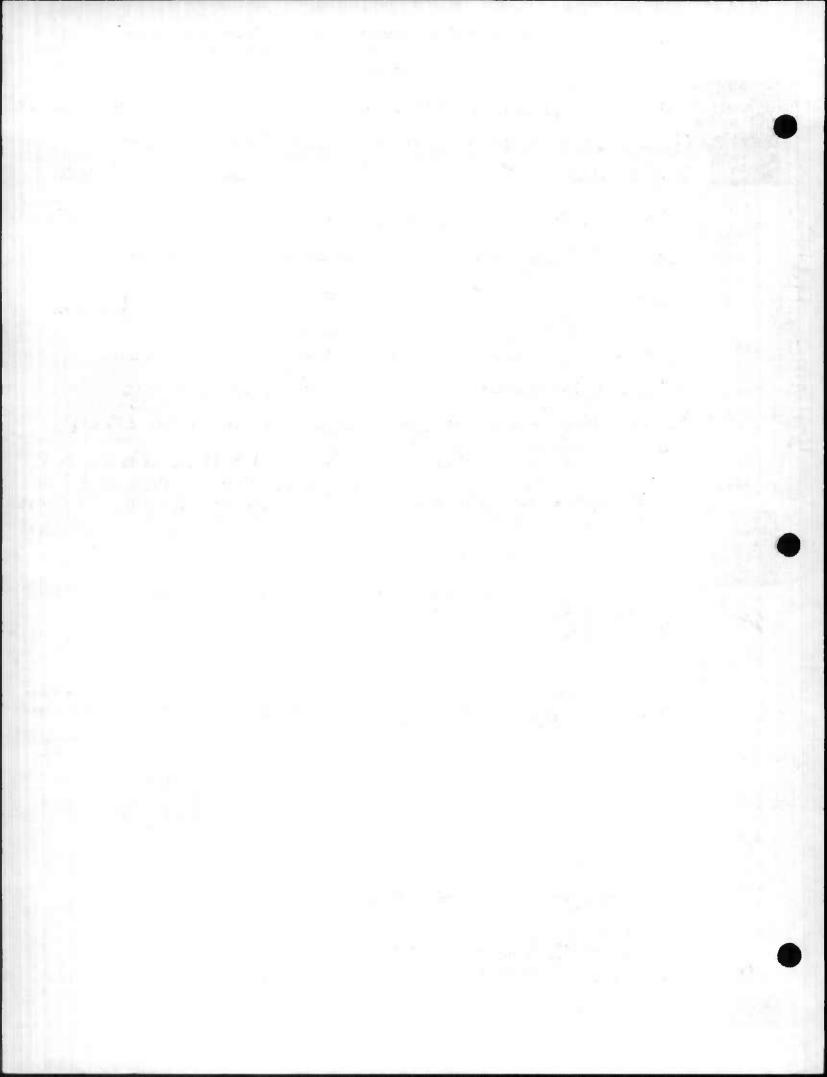
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Williams Month :20 pm HATTIE VANCE Januar 4a. Facility Nama (If not institution, giva street and number) 4b City, Town, or Location of Daath 4c. County of Death 1 mole JANDE If Undar 1 Yaar JENESIS (ATON If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6. Sax 9. Birthplaca (Stata or Foraign 1 M 2 M 238-20-063 Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Tas 2 No ltimore 10 Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 225 N SHREET USA Funerai 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No by Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) leth NA Tarm 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnema) JARd Rick Kleck Stallings (9a. Informant's Name Halationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rurat Route Number, City or Town, Sata, Zip Code) · CulvER Dalto. 225 N 21229 Pavahter JERNICE DOW 20b. Place of Disposition (Nama of camatary, exematory or other place, 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dapt. Ch. Cem.

22. Nama and Addrass of Facility

C. March 18 Burlal 2 Cramation 3 Ramoval from Stata 1.31.98 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signal yre of Funarai Sarvica Licensaa 21215 4300 Wabash 23a. Part1. Enter the disalse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Dua te (or es a consequence ot): reflections / nac Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseesa or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 ☐ Unknown by 24a. Was an autopsy performed? 24b. Wera autopsy findings availebla prior to complation of causa of daath? Completed 1 ☐ Yas 2 No 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28e. Data of Injury (Month, Day Yaar) 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury et Work? 5 Pending invastigation 1 Alatural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homlcida edicai 29a. Certifiar 1x Certifying Physicien: To tha best of my knowladga, daath occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and mannar statad. 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) Altendry 1-26-58 D21684 Doctor 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

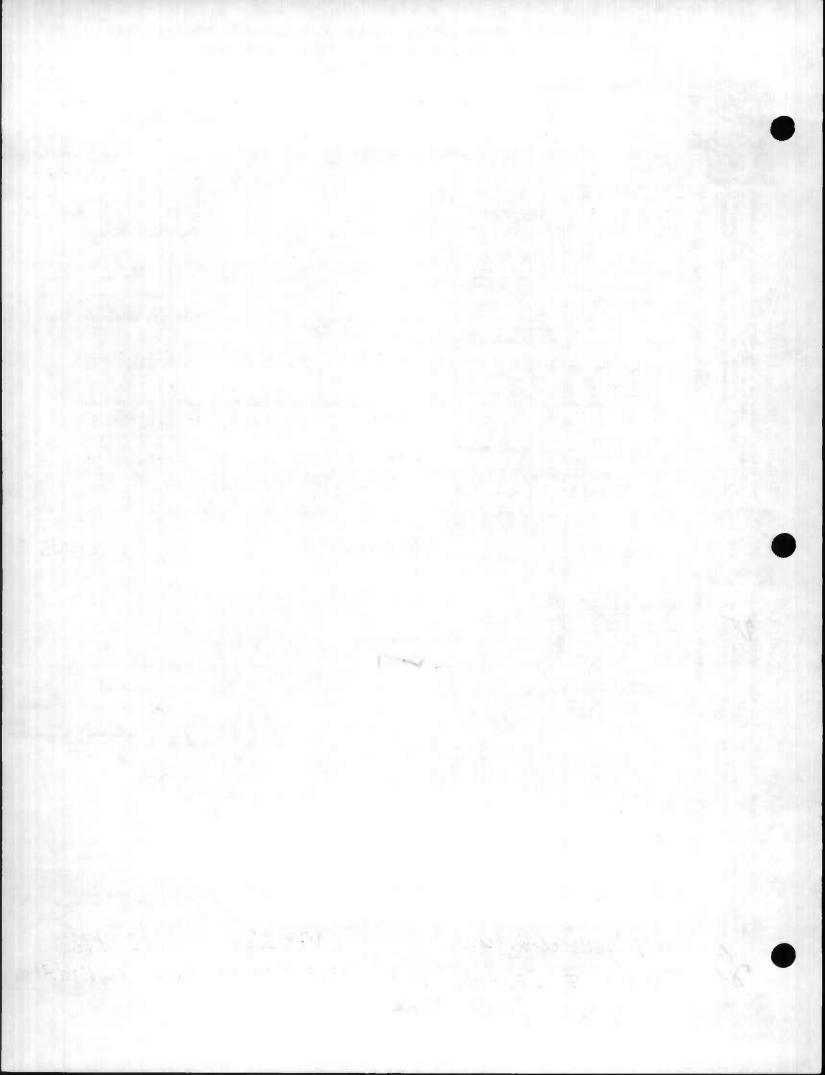
CN-C4RIAC-MD \$109 RITCHIR OWT, PASADENA, MD 21122 31. Data filad (Month, Day, Year)
JAN 27 1998 32 Ragellar's Signal Pandelle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Year **Physician** 2 3 Catherine N. Walker 1998 2:30 PM JAN /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 857 Scenic Hills Way Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Deys Months 1□ M 2X F Yrs. 578-34-6627 Director 69 APR 7, 1928 Pennsylvania Usual Residence of Decadent deeth with the Merylend 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 28a-f ahov tre Medical Examinar must be notified at MD Y□ Yes 2□ No Anne Arundel Annapolis Director 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 857 Scenic Hills Way 21401 Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours efter ☐ Yas 2 No Yes, Give 1 Navar Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry filed withIn Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 7 is marked other traumetic event, ii 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be fill ment of Health and Mental Hent: If Item 27 is marked oth jury or other traumatic even Be George F. Nonamaker Catherine K. Kittell 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stele, Zip Code) John B. Walker/husband 857 Scenic Hills Way Annapolis, MD 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) permit. Pege Depertment of Important: If eny injury or once. Metro Crematory, Inc. 01/24/98 Baltimore, MD 22. Name and Addrass of Fecility
Cremation Society of Maryland, Inc. 21. Signature of Fungral Service Lice 1C Smalo Dawn 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar the disaasa, or complications that causad tha daath. Do not antar the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onsat and Death **Physician** Sarcoma /Medical Immediate Ceuse (Final ZUMOS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of) signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performad? Completed Is certificate has director, page 2 2 No 1 □ Yes 2 □ No 1 Yes Attending Physician: 25. Was cese referred to medical examiner? Be 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation or Attendent efter deat Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 hou. 4 Homicide Hospital 24 hours 8 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29d. Data sighed (Month, Dey, Year) 29c. Licensa numbar 29b. Signature end title of certifiar M.O. 30 Nemoderal endress of person who completed cause of deeth (Item 23e) (Type, Print) 900 Bestacte Annapolis, Wd. 21401 vauf Mil. Paritrer's Signature 31. Date filed (Month, Day, Yeer) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month January 24, 1998 **Physician** Sue Sumei 7:30 AH /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3234 Abell Avenue Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Yeer 5 Social Security Number If Under 24 Hrs. 9. Birthplece (Stete or Foreign **Funeral** Deys 10 M 20 F Taiwan 539-58-1916 53 Yrs. Feb. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified. Yes 2□No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3234 Abell Avenue 21218 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: þ Specify: Oriental 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Researcher/Writter Johns Hopkins Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be P unk 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shi-Chang Wu (Husband) 3234 Abell Avenue, Baltimore, Maryland 21218 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Bunal 2 □ Cremetion 3 □ Removal from State Dulaney Valley Mem Gdns 1/30/98 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiopulmonary arrest 3 minutes **Examiner** Due to (or es e consequence of) Examiner 2 years Squamous carcinoma of tongue Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physiclan/Medical Due to (or as e consequence of): 58 attending Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ŝ signed by d be detact 1 Yes 2 No 3 Probably 4 Unknown Bleeding, Weight loss by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 500 has **D808 2** 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 2 蓄 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Affar 5 Pending Investigation death 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours at To the Funeral Di 1 🚣 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the besis of examination end/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19328 01/26/98 20

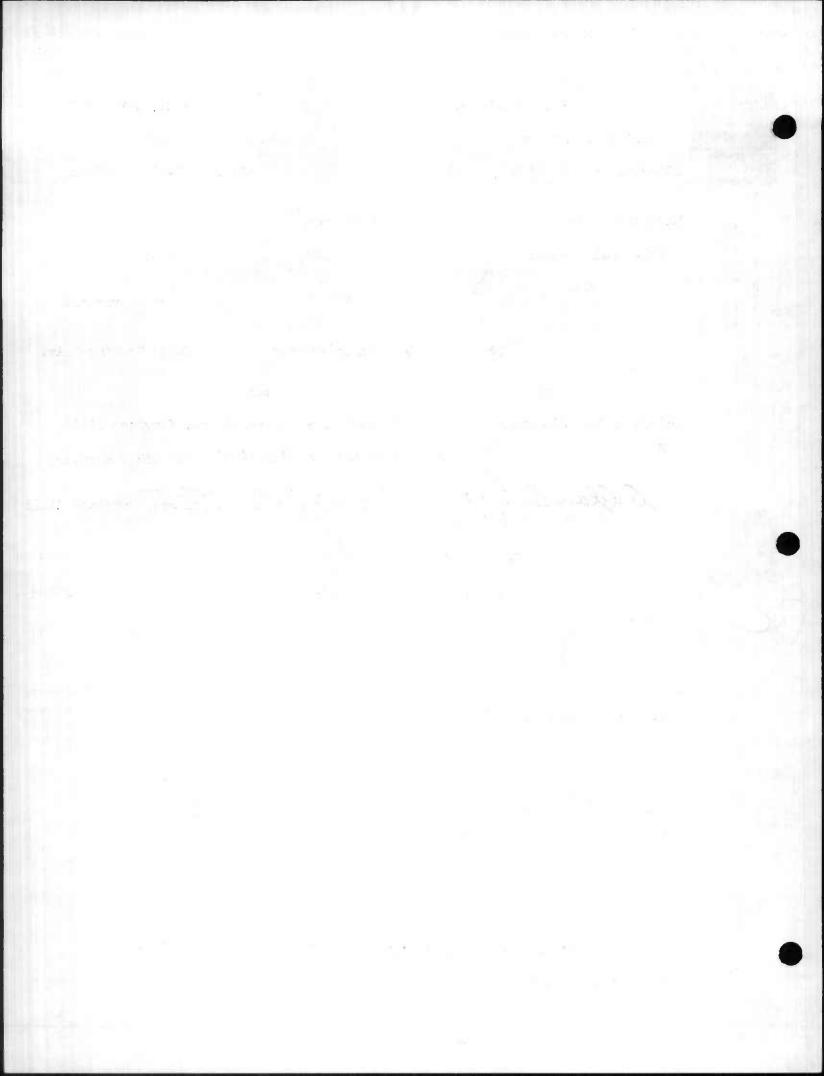
Registrar

31. Dete filed (Month, Day, Year)

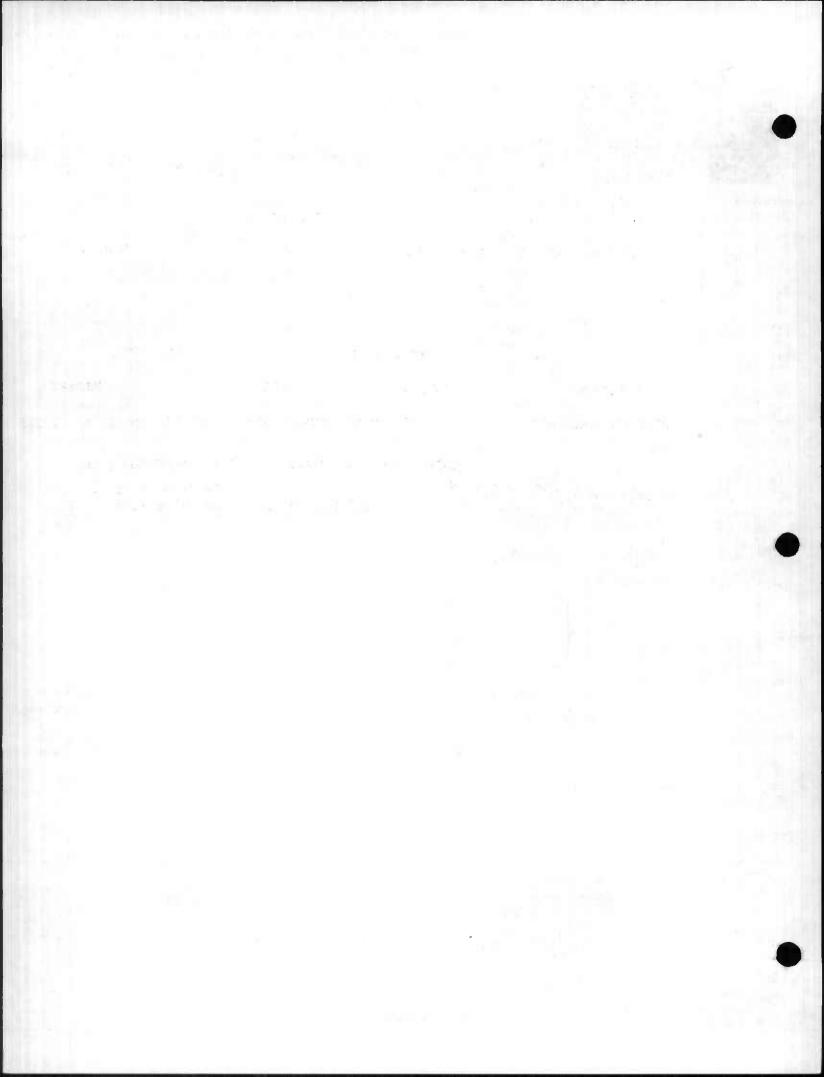
30. Name end eddress of person who dompleted cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signature rulia Davidson

Johns Hopkins Hospital/ 600 N. Wolfe St./ Baltimore, Maryland

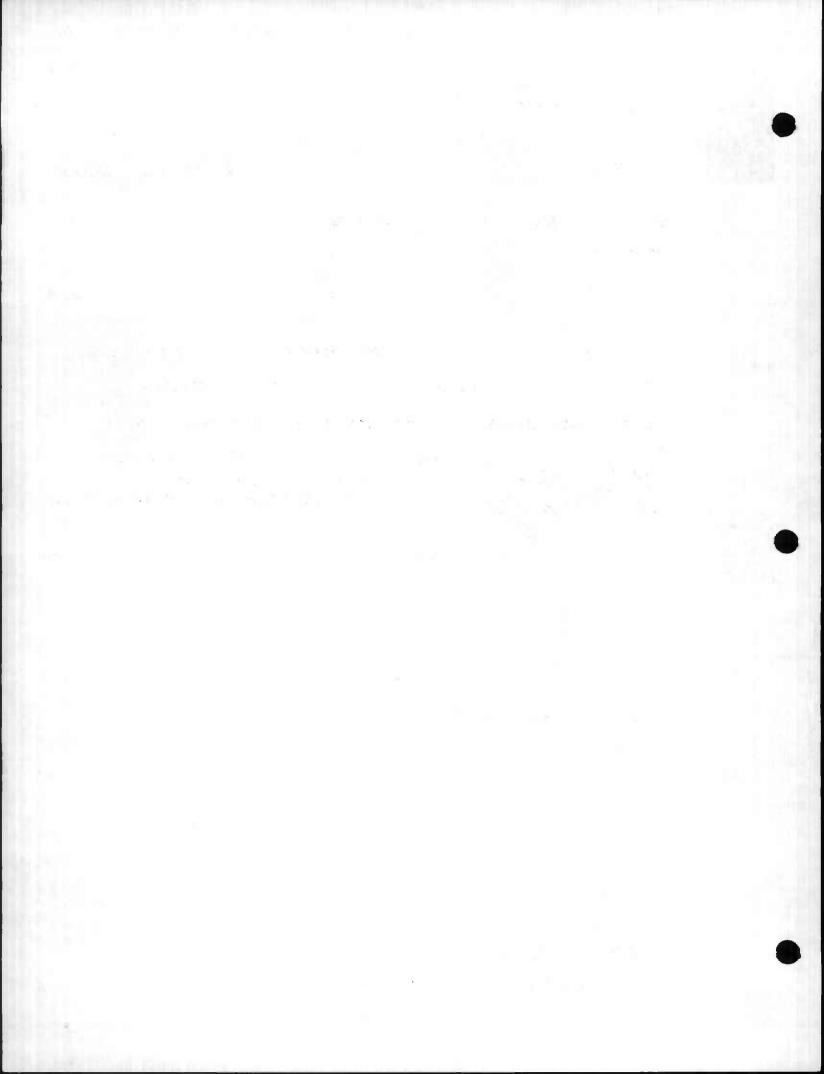


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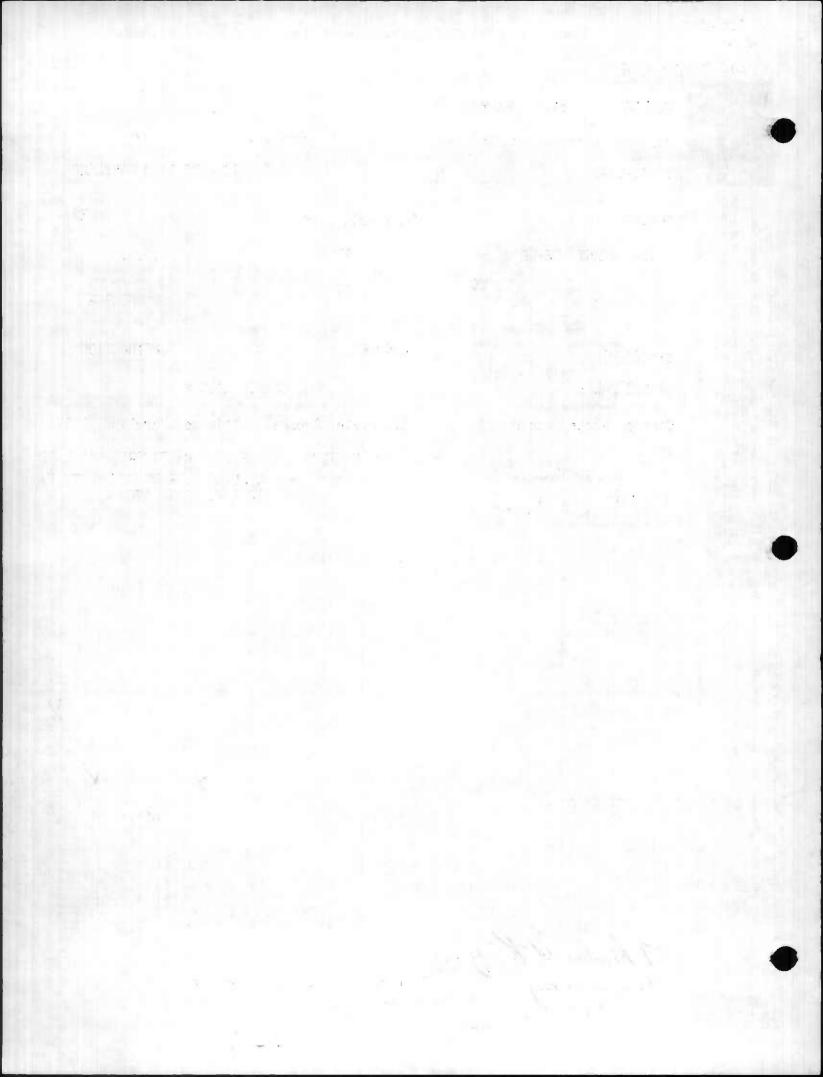


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	163						Ce	rtificate	of l	Death		Reg. No.	U	1851
	Physic	ian	Decedent's Name (First,								2. Dete of D Month	eeth Dey	Year	3. Time of Death
	/Medi				ner						Janua		1998	1:05AM
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ı	Funeral Director	6	5. Social Security Number 212-03-9755		Sex 1 M 2□ F	. Age (In yrs. k		Months C	Yeer Deys	If Under 24 Hrs Hours Min.		rth e <i>y, Year)</i> 15, 1909	9. Birthp Coun MAF	elece (State or Foreign etry) RYLAND
	nyland		Usuel Residence of Deced 10a. Stete 10b. 0			10c. City	, Town or L	ocation	198				1	0d. Inside City Limits
	a Ma	Director	MD	N	/A		В	ALTIMOR	RE					1 Yes 2 No
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	th wi	ai	3003 ROMARI	C CT				2	212	09		USA		
21215-0020	be filed within 72 hours after death with the Maryland ntal Hygiena. Id other than "natural", or itema 23a or 28a-f show event, if a Modical Experient must be notified at	by Funeral	11. Marital Status 1 Never Married 2		12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Yeer or Dat	es? LXNo	5. 13.	Was Decedent of Hispenic Origin? (Specify if Yes, specify Cuben, Mexicen, Puerto Ricar □ Yes 2 X No Specify:				0- 14. Rad Bie Specif	ce - Americ ck, White, y:	
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yla	should be and Mental marked o	10	PHILIP			WARNER				EVA	S	MOLARTZ		
a	d 2 should th and Mer 7 is marke traumatic		19a. Informent's Name/Re	ationship	(Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number,							, Stete, Zip	Code)
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Ĕ	ant and		1 N Burial 2 □ Crem 4 □ Donation 5 □ On			alo	AI IS				22/98	BALTI	MORE,	MD
alti	in injury		21. Signatur of Funeral S	Avice Ligh	200		2	2. Name and	Addres	s of Eacility	PPOG	TNO		
Ö	Dapa Impo any i		21. Signature of Grand Service Libertus. 22. Name and Address of Eacility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE										MD 01000	
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	Dhusisian		Sa. Bart Enter the diseasing shock, or heart failure	List only	one came on each	ch line.	. Do not on	nor the mode c	or dynn	g, 30011 63 Carola	o or respiretory	J11631,	1	Intervel Between Onset end Deeth
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87	ata hysi	edicai	thet initieted events resulting in death) Lest		Due to (or es e consequence of):									
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Division	aftar d Direct	F	Suicide determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number of City or Town, Stete)									oer or nure	i Houte Number,	
171	To the Hospital of Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		20-0-45-											
-	工工工	edical	29a. Certifier (Check only one)	rtifying Pl dical Exa	hyeician: To the be miner: On the bas	is of exemination	rledge, deat on end/or in	h occurred et t vestigation, In	the time	ie, dete end place pinion, death occu	e, end due to the urred et the time	ceuse(s) end me , dete end plece,	enner es st end due to	eted. the ceuse(s)
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	T V		29b. Signature and title of o	ermer.	2	Intern.	in			number		29d. Dete signe		
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			Anna Abrah		no sina	i Huspi	tal,	240/We	1	Belvooler	e Avenu	ie, Bait	more,	manyland 21215
	Sta		31. Dete filed (Most) Day,	Year)	32. Reg	pistrar's Signeti	ure							
	Registr	ar		. 12	30	ma way	son-ga	ndelle						



M	TLLTE F	DW.	ARD WALKER	State of M	Maryland		artment of I			ntal Hyg	ene 8	01	858	
Ite	ms:23a pa	rt	ARD WALKER 1,27,28a-f per MEO G-7 1. Decedent's Name (First, Middle, Las	55 1/29/98	dh	Cel	tificate of	Death		. Date of Deet	g. No.		3. Time of Death	
п	Physicia		WILLIE EDWAR		-R					Month JAN.	Day	Year	0927 AM	
4	/Medic Examin		4a Fecility Name (If not institution, give					4b. City, Tov		tion of Deeth	4c. County		0921 AM	
	LXuiiiii	٠,	1124 NORTH FREMO	NT AVENU	E			BALT	IMORE		N/	Α		
	Funeral		5. Social Security Number 6. Se	9x XXM 2□ F	Age (In yrs. la		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min.	Date of Birth	Year)	9. Birthp	lace (State or Foreign	
	Director		213-02-3040	CPM ZUF	37	Yrs.				JUNE 22	1960	MARY	AND	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits	
	Mary Fed sh	to	MARYLAND N/A			BALT	IMORE CI	TY					XX Yes 2□No	
	r 28s	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	try?	
	ath with the Marylan 23a or 28a-f show		2214 BRYANT AVE	NUE			2121			U.S.				
	items items	Funeral	11. Marital Status	12. Was Deceder Armed Force 1 Yes	nt Ever in U,S	i. 13. \	Was Decedent of I	Hispanic Orig	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		e - Americ		
20	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give			1□ Yes 2 No	Specify:			BLAC	CK		
9	72 hours after death with the Maryland *naturel', or itema 23a or 28a-f ehow tolical Examiner must be notified at	Pg p	15. Decedent's Ed	Yeer or Dates	*	16a Decec	lent's Usuel Occur	Isuel Occupation 16b. K						
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mo	00-		X1X Burial 2 Cremation 3 4 Donetion, 5 Other (Specify		A		natory or other pla N CEMETE		1	-27 E	BALTIMO	RE. N	MARYLAND	
Baltimore,	permit. Pag Department Important: It any Injury o													
Ö	Den		21. Signature of June all Service Ucenhood 22. Name and Address of Facility WILLIAM C.BROWN COMMUNI 1206 W. NORTH AVENUE											
			23a. Pert1. Enter the disease, or composhock, or heart failure. List only	lications that caus	ed the deeth.	Do not ent	er the mode of dyi	ng, such es	cardiac or r	espiretory arre	st,		Approximate Interval Between	
	Physician		Shock, of heart failure. List only c	one cause on each	iirie.							!	Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition	a ALCO	HOL & NA	RCOTIC	INTOXICAT	ION						
	LAGIIIIIIei	_	resulting in death)		Due to (or	as a conseq	uence of):							
	pet list	Examine		b										
,	death certificate be executed e attending physician and ed for use as the burial-transit	Exal	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury c.									1		
8760,	ate be hysicia the bur	cal	that initiated events	C	Due to (or a	as a conseq	uence of):							
9	ng ph	S S	resulting in death) Last					i						
Box	sath certifice attending ph of for usa as t	lan		d										
	the a	Physician/Medical	Part II. Other significant conditions co	ntributing to death	but not result	ting in the ur	nderlying cause gi	ven in Part I.		23b. Did to	becco use co	ntribute to	the cause of death?	
P.0	es that the digned by the be detached									1 🗆 Ye	s 2 No	3 Prol	pably 4 Onknown	
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00	w require been si should	Completed								perform		co	ailable prior to mpletion of ceuse death?	
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ta		0	25. Was cese referred to medical					26. Place	of Death (Check only on			(100 2010	
of Vital	5 00	To B	examiner? NOXYes 2 □ No	Hospital: 1 ☐ Inpa	tient 2 E	R/Outpatien	t 3 DOA Ot	her.		5 ☐ Reside		er (Specif	VACANT	
	ding Ph. After thi funeral	- 1	27. Menner of Death 1 □ Natural 5 □ Pending	28e. Date of In (Month, L	jury Day Year)	28b. Time of Injury	A 28c. Inju	ry at rk?	28	d. Describe ho	w Injury occur	red	noose	
Sio	Attending ir death. actor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6XXCould not be	found 1/		ound 9		Yes 2/X	ui	known				
Division	or Attendi a after death I Director: A d in by the f	Certification:	4 Homicide determined	28e. Place of I building,	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28	City or Town	State) 112	N. I	remont St.,	
ш	Hoepital	Ö	29a. Certifier 1☐ Certifying Phy	found in			occurred at the ti	me date and		Itimore,		anner se e	Pated	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edicai	(Check only one) Medicat Exam		of examination									
	within 2 To the comple	Z E	29b. Signature and title of certifier				29c. Licen	se number		25	d. Date signe	d (Month,	Day, Year)	
	+1		The Said	11	200		0.	C.M.E			JAN.	2, 19	97	
		-	30. Neme and address of person who c	ompleted cause										
_			1/E-POINT MIKE	4.	-		nn Stree	t, Bal	Ltimor	re, Mar	y Land	21201		
	Stat	е	31. Date filed (Month, Day, Year)	32. Regis	Parks Signatu	HI AMA	and D							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1859 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3 Time of Death / Month **Physician** anuary /Medical 4b. City, Town, or Location of Death

BALTIMOTE

If Under 24 Hrs. 8. Data of Birth 4a. Facility Name (If not institution, giva streat and number Examiner 65DITAL MARYLAND GENERAL If Undar 1 Yaar If 5. Social Security Number Aga (In vrs. last birthday) Data of Birth (Month, Day . Sex. 12 M 2□ F 9. Firthplaca (Stata or Foreign Country) **Funeral** Months Days 213-28-8190 Yrs Director Marylanc Usual Rasidence of Dacedant 10a Stata 10d. Insida City Limits 10b. Count 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Yas 2 No Maryand Director mor 10e. Street and Numbay 10f. Zip Coda 10g. Citizan of What Country? ŏ 56 Items 23a 12 2 Funeral (12. Was Dacedant Evar in U,S. Armed Forcas? 1/D Yas 2□ No I/Yas, Giva Yaar or Datas: 13. Was Dacedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian Black, Whita, atc. 1 □ Navar Married 2 □ Marriad permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or I amy injury or other traumatic event, the Madical Examt once. 1 Yas 2 No Specify: Maryland 21215-002 ğ ace 3 Widowad 4 □ Divorced Completed 15. Dacedant's Education 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Spacify only highast grada completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) +1 porer onstruction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mark BOX-HUDSON Son rnalan Baltimore. Mathod of Disposition

Burial 2 Cramation 3 Ramoval from Stata 20c. Location - City or Town, Stata
OWINGS Mills Mary and 20b. Plece of Disposition (Nama of cematary, cramatory or other place) Data -30-5 Dether (Specify) Forest Garrison 21. Signatura of Funaral Sarvice 22. Nama and Addrass of Facility

LOVIN P. Carroll Funera Ave. Baltimore 1712 W. North Maryland 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physician /Medical Immediate Ceusa (Final adder with Obstructive disaasa or condition rasulting in daath) rcinoma Examiner Physician/Medical Examiner Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disaasa or Injury that Initiated avants rasulting in daath) Last Records, P.O. Box 6876 The law requires thet the death certificate ettending for use as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? Malnutrition 1 ☐ Yas 2 No 3 Probably 4 Unknown Completed by 8 cete has been sig , page 2 should t 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy 1 Yas 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to Be 25. Was casa rafarrad to medical axaminar? 26. Pleca of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpetiant 2 □ ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how injury occurred Natural 2 Accidant 5 Panding investigation 1 Yes 2 No 3 Suicida 6 Could not be 26f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 4 Homleida Certifying Phyalcian: To the bast of my knowledge, deeth occurred et the time, dete and ptece, and dua to tha causa(s) end manner as statad.

2 Medical Examiner: On the basis of axemination end/or invastigation, in my opinion, death occurred at the time, date and ptace, and due to the ceuse(s) and mannar statad. 29a: Certifian 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) MD

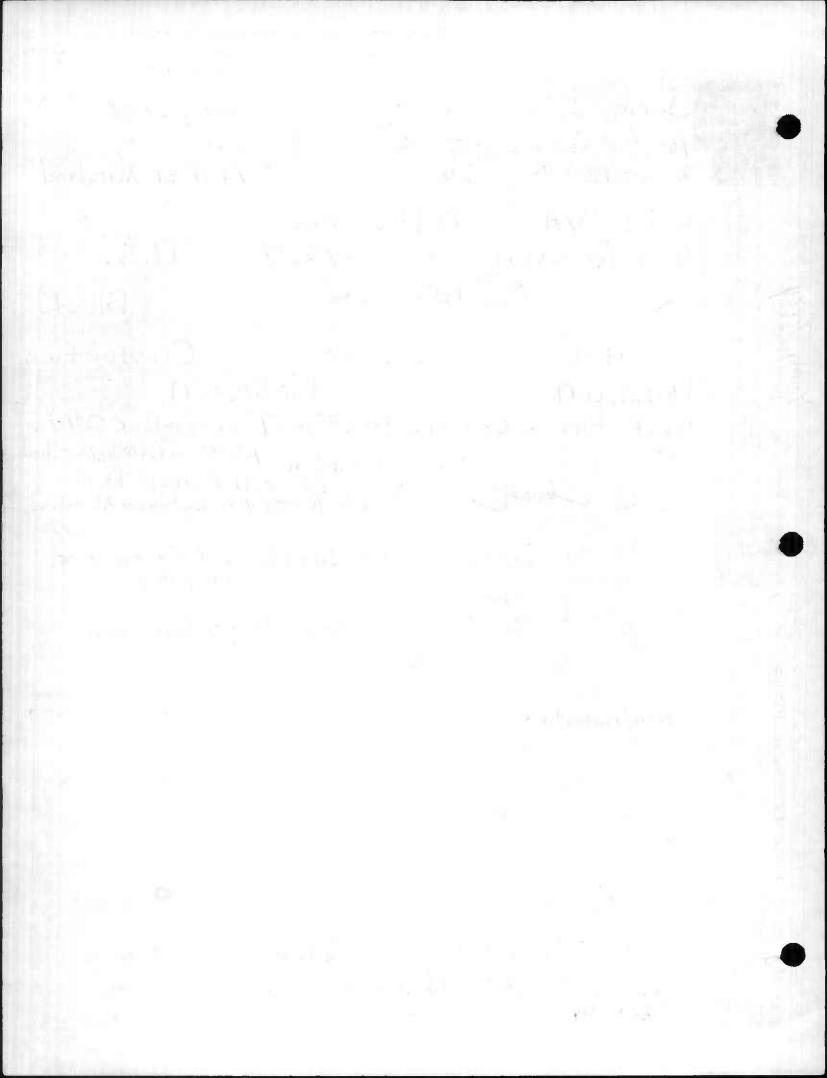
State Registrar 30. Name and eddrass of parson who complated causa of daath (Itam 23a) (Typa, Print)

(Month, Day, Year)

M. D. Co //
P33. Ragistrar's Signature

Man franchists

MARYLAND GENERAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** 1916 RENE 400 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** SINAT HOSP 1792 Baltimore If Under 24 Hrs. 8. Dele of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer 9. Birthplece (State or Foreign **Funeral** 1□ M 3(C)(F Months Devs Yrs. 68 FEB. 4, 1929 MARYLAND Director 216-22-4474 Usuei Residence of Decedent 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2 No Director MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10g. Citizen of Whel Country? 4503 PIMLICO ROAD U.S.A. Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes * A No If Yes, Give Yeer or Dales: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 11th grade NURSING NURSING HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be FRANK GISSENTANER MYRTLE GISSENTANER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Samuel Yow/ Husband 4503 Pimlico Road, Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stele 1) Suriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) GARRISON FOREST VETERANS 1-28-98 OWINGS MILLS, MARYLAND 21. Signature of Funeral Servica Licensee 22. Neme and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. MORTH AVENUE 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical MYOCARDIAL INFARCTION Examiner Due to (or es e consequence of): Physician/Medical Examiner HMPERRY SION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequença of): NIDDM Records, P.O. Box 68760. Due to (or es e consequenca of): attending p Hyractocs From A Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBESTIN MUNCISIO þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed peen page 2 1 Yes 2 2NO 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: efter death. Director: After this certifica 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospilal: 1 ☐ Inpetient 2 ER/OutpetienI 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 ☐ Certification: To Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred of the lime, date end place, and due to the cause(s) and manner stated. (Check only one)

11 State Registrar

SAMUEL 31. Dete filed (Month, Dey, Year)

29b. Signature end title of continue

32. Registrer's Signeture what sindson Amount

MO

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Woo

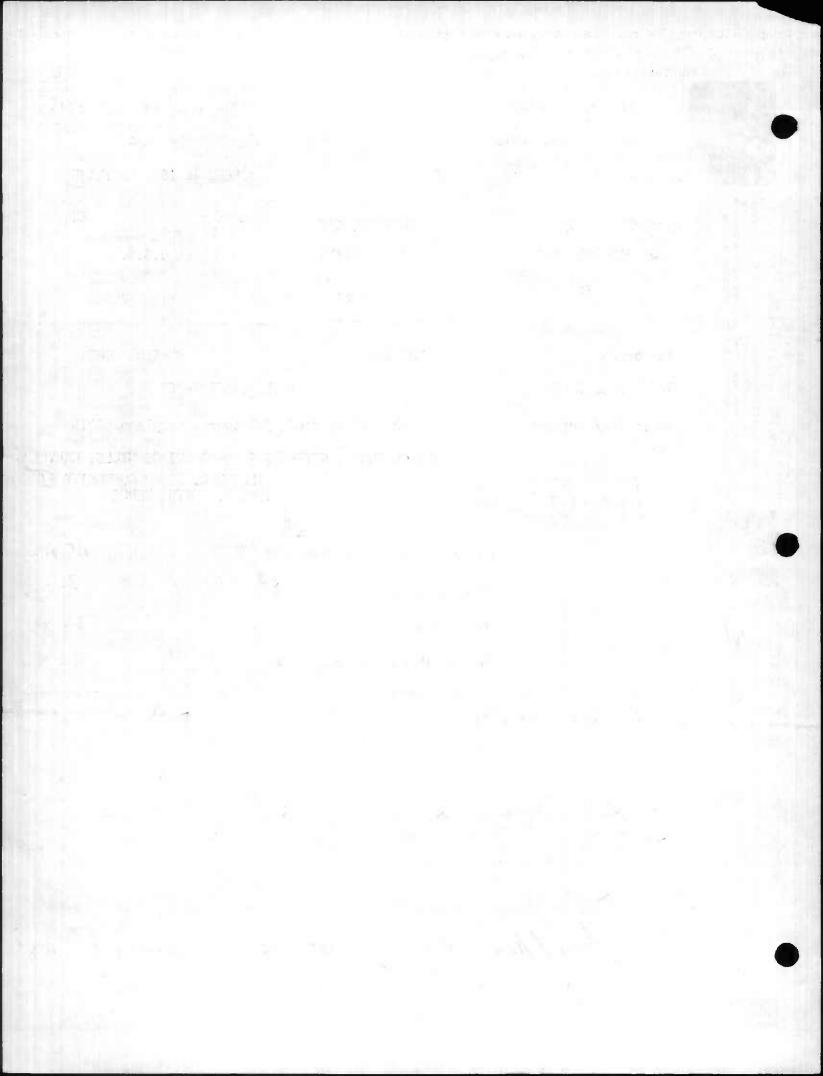
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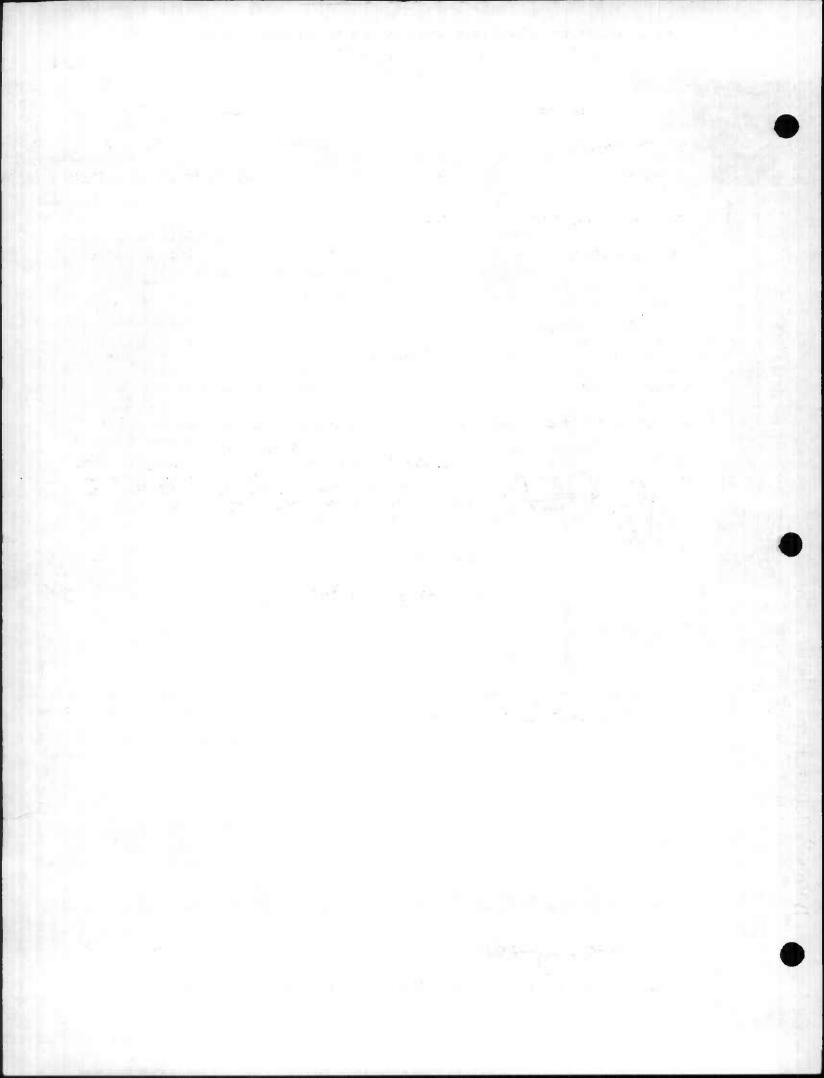
29d. Dale signed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene 98

							C	ertifica	te of	Death		Reg. No.	0	100	, ,
		Dhamisi		1. Decedent's Name (First, Middle, L	ast)				3		2. Dete of D	eath	V-4-	3. Time	of Death
-		Physici /Medic		Mary P. Achstett	er						Januar Januar	Day 13. 1	Year 998	3:4	5 AM
		Examir		4a. Fecility Neme (If not institution, g		ber)				4b. City, Town, o	r Location of Dee		nty of Deeth		J 1111
				Suburban Hospital 5. Social Security Number 6.				, If I Indi		Bethesda			gomer	-	
		Funeral Director		577-05-9806 Usuel Residence of Decedent	Sex 7 1□ M 2X F	'. Age (In yrs	30 Yrs.	Months	er 1 Year S Deys	Hours M	n. (Month, D	irth Pey, Year) 16,1917	9. Birth Cou Wash	place (State intry) ningto	on, DC
	land	No to		10a. Stete 10b. County		10c. C	ity, Town or	Location						10d. Inside	City Limits
	he Mary	r 28a-f show	ector	Maryland Montgor	nery	I	Bethes							1 □ Ye	s 2 No
	ith with t	23a or 2	Funeral Director	10e. Street end Number 6307 Stoneham Roa	ıd				ip Code 0817			10g. Citizen o		•	
	d Z1Z15-UUZU filed within 72 hours after death with the Maryland Husians	at', or items 23a or Examiner must be	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	ces? ☑ No	U,S. 13	3. Was Deci If Yes, sp 1 \(\superscript{\text{Yes}}\)	ecify Cuba	lispanic Origin? an, Mexican, Put Specify:	(Specify Yes or Nerto Rican, etc.)		ace - Ameri leck, White, cify:		
	2-C	"natural",	ed	15. Decedent's (Specify only highest g	Education		16a. Dec	cedent's Us	ual Occup	etion	en elelin m	16b. Kind of	Business/Ir	ndustry	
5	Z1Z15-00Z0 d within 72 hours aff	Hygiane. other than *	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		emake		during most of w	orking	Own	1 Home		
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	Maryland d 2 should be file	h and Mental P	To Be	Gustav Pauls							oretta (
-	Shoul M	mar.	-	19e. Informent's Name/Relationship	(Type, Print)		19b. Ma	ailing Addres	ss (Street		Rurel Route Num		n Stete Zi	in Code)	
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3	ballinore, bemit. Pages 1 ar	Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other tranmatic event, once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removel from St	20b.	Plece of Dis cemetery, cr	position (Ne rematory or	eme of other plea	≫)Jan. 1		20c. Location	n - City or To	own, State	
	it. Pu	rtant		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lio	-	St	. Mar					Washing			
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Achstetter Mila Beards	The law requir	s been s 2 should	Completed								24e. We	s en eutopsy formed?	ev	ere eutops: veileble prio ompletion o deeth?	rto
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46	Physician:	this ceral dire	0	1 Yes 2 No	Hospital:		ER/Outpeti	ient 3 D	Oth Oth	er: 4 Nursing	Home 5□ Res	sidence 6 🗆 O	ther (Speci	(ty)	
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ary P.	al or Atte	in Direct	Certification:	3 Suicide 6 Could not determined	288. PIECE 0	f Injury - At h I, etc. <i>(Speci</i> i	ome, farm, s	street, factor	ry, office		28f. Location City or To	(Street end Νυπ own, Stete)	ber or Run	el Route Nu	m <i>ber</i> ,
3	• Hospital or	e Funeral	edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	nyelclen: To the be miner: On the bas end menne	is of exemine	owledge, dee etion end/or I	eth occurred Investigation	d et the tim n, in my o	ne, dete end ple pinlon, deeth oc	ce, end due to the curred et the time	ceuse(s) end n , date end place	nenner es s , end due t	steted. o the ceuse	o(s)
	To the I	Toth	Me	29b. Signature end title of certifier				29	c. License	e number		29d. Dete sign	ed (Month,	Dey, Year)	
•	18) Deces	2 M).			04	4157		THURE	y 13, 19	998	
				30. Name and address of person who	completed ceuse	of death (Item	m 23e) (Type	e, Print)	d, R	ockille	e, may	erg Fra	1881		
		Sta	te	31. Dete filed (Month, Day, Yeer)	32 Reg	istrer's Signa									



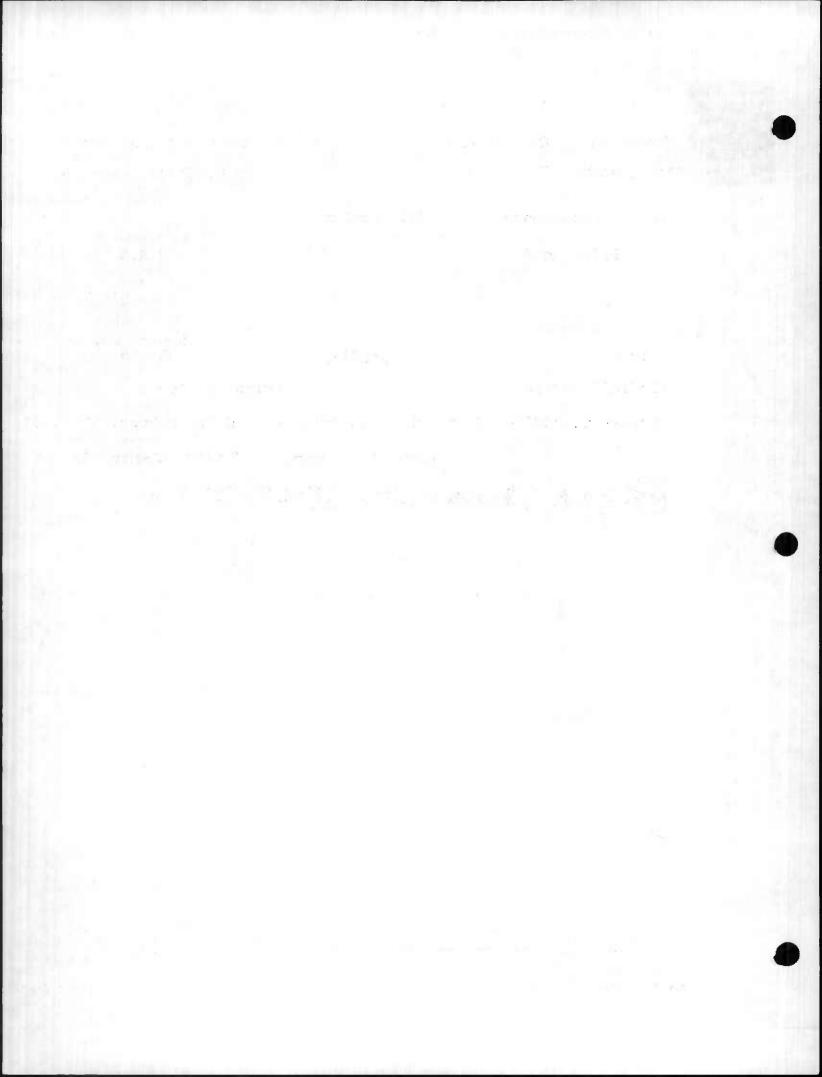
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month 1998 PAUL. E. ADDISON Jan 7:Pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Manor Health Care Center Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. (Month, Day, Year)

Feb. 7, 1940 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2□ F Yrs. 213-38-9777 57 Director Maryland Usual Residence of Decedent 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28s-f show Examiner must be notified at MD Director Gaithersburg 1 ☐ Yes ¾☐ No Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 8120 Brink Road 20882 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armad Forcas? 1 ☐ Yas 2 22 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 Widowed 4 Divorced "natural", Completed traumatic event, the Madical 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed within Department of Haalth and Mental Hygiane. Important: if Itam 27 is marked other than "reany injury or other treumatic event." Montg. Co. Elamantary/Secondary (0-12) College (1-4or 5+) Schools 12th Custodian 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Winfield Addison Harless S. Booze 19e. Informent's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Steta, Zip Coda) Harless S. Addison (Mother) 8120 Brink Rd., Gaithersburg, MD 20882 20b. Plece of Disposition (Nama of camatary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State Metropolitan Crem. 1/14/98 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signaldly of Funeral Service Lighteen 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediata Causa (Finel e. Branc. preum == 1 a

Due b (or as a consequence of): disease or condition resulting in death) Examiner Examiner physician and s tha burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury thet initieted events rasulting in daeth) Last P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): attending p Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause 24e. Wes an autopsy Completed of daath? page 2 certificata 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director; to 25. Was casa raferred to medical Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 27. Menner of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 1 -Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straet, factory, offica building, atc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowladga, daath occurred at tha time, dete end plece, and due to the cause(s) end menner es steted.

2 Medicat Examinar: On the best of exemination and/or investigation, in my opinion, daeth occurred et the time, dete end pleca, end due to tha causa(s) and mannar stated. Medical 29a. Cartifiar 29c. Licansa number 29b. Signature and title of cartifier 29d. Date signad (Month, Day, Year) D33357 30 Name and address of person who completed causa of death (Itam 23a) (Type, Print) 5530 Wisconsin Are Chang Chan his Logis Musher Than 32. Radistrar's Signature State Fulia Davidson-Randolla Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** IRVING ARTHUR JAN 2:10 Am 1998 11 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING

If Under 24 Hrs.
Hours Min.

8. Data of Birth
(Month, Day, Year) HOLY CROSS HOSPITAL MONTGOMERY 5. Social Sacurity Number 6. Sex M 2□ F If Under 1 Yaar 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days 90 Yrs. JUNE 8, Director 577-05-7909 MD Usual Residence of Deceden with the Meryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 ☐ Yas 2 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15115 INTERLACHEN DR., #608 20906 USA death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 M No It Yes, Give Year or Dates: 14. Race - Amaricen Indian. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item my linjury or other traumatic event, Ite Med cal Examination. Black, White, etc. 1 Navar Married XX Marriad 1 Yes 2 No Specify: Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) MANAGER SHOE STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Be MORRIS ARTHUR P KATTE MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) STEVE SELTZER / SON-IN-LAW 1709 GLASTONBERRY RD., POTOMAC, MD 20854 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ELESAVETGRAD CEMETERY 1/13/98 WASHINGTON, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS 23a Part. Enter the dease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, and or heart divine. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 Week Septicemin Examiner Due to (or as a consequence ot): Examiner 2 Namme Week physician and s the buriel-trans Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 99 Physician/Medical Dua to (or as a consequence of): as esn for the ? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by Atherschenter HENT Disease With Prengker Division of Vital Records. þ 2 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peen page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was cese reterred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 2 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time ot 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number MO MAD 09748 1/11/98 Wenstork

Registrar

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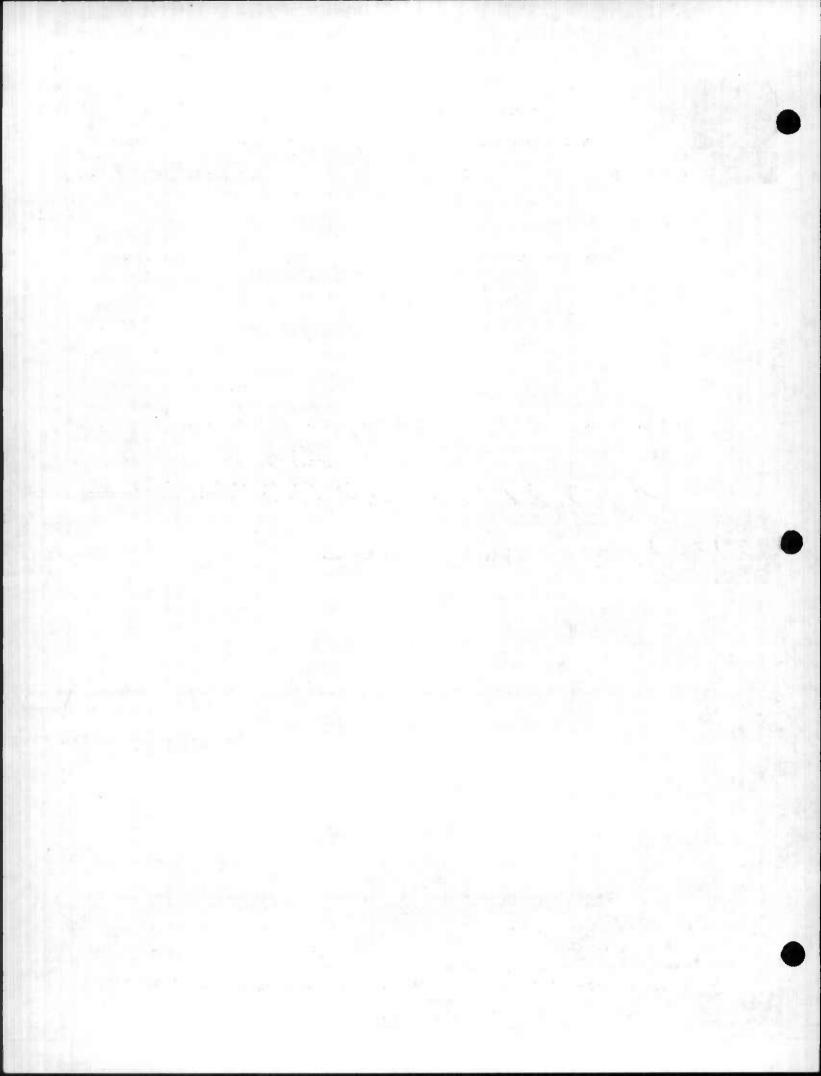
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30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 8

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П	Funeral	Г	5. Social Security Number	6. Sex	7. Age (In yı	s. lest birthday,	If Unde Months	er 1 Year	If Under		8. Date of B	irth	e)	9. Births	olece (Ste	te or Foreign
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	ep .	ne	11. Marital Status	12. Was De	cedent Ever in orces?	U,S. 13.	Was Dece	edent of H	lispanic Or	igin? (Sp	ecify Yes or N Ricen, etc.)	0-		ce - Americ		9
0	or it		1 ☐ Never Married 2 📉 Marrie	ed 1 Yes	2 No						7 1110011, 010.7				eic.	
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Baltimore, Maryland	s 1 and free free free free other		20e. Method of Disposition			Place of Dieny	neition /A/o	ma of	-		Date			City or To		_
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≥.	after Direction by	ŧ	4 ☐ Homicide determin	ed build	ling, etc. (Spec	home, ferm, str cify)	eet, ractor	y, office			28f. Location (City or To			er or nura	i Houle iv	umber,
	is Sign															
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	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	one) 2 Medical E	caminer: On the b	ner stated.	etion end/or in	vestigetion	i, in my o	omion, dee	tn occur	red et the time,	dete er	ia biece,	ena aue to	the ceus	B(S)
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			James F. Barter,	M.D. 38	00 Res	ervoir	Road	N.W.	Wasl	ning	ton, D.	С,	2000	7-219	7	
	Sta	te	31. Dete filed (Month, Dey, Year)		egistrar's Sigr											
	Registr	ar	JAN 12 1	992	lin Kan	1 50 .										



Physician /Medical Examiner

that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Physician

/Medical

Examiner

10a, Stata

Directo

Funeral

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Completed

Funeral

Director

the Manylenc

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelih end Mental Hyglena. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show sup injury or other traumatic event, the Woolcal Examinat must be notified at once.

Examiner attanding physician end for use es the bunal-transit Physician/Medical à Completed page 2 Be P

signed by the a

Deen has

certificate

this

funeral director,

filled in by

edical

29b. Signature and title of cartities

Thomas C. Havell,

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

H

32. Registrar's Signatura

hia Davidson-Randolle

Attanding Physician:

if or Attanding Pt after death. I Director: After th

Hospital 24 hours

To the Hosp within 24 ho To the Fune completely fi

Certification:

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Generalized Arteriosclerosis 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ KNo 25. Wes case reterred to medical axaminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Neturai 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and dua to the cause(s) and manner as ateted.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one)

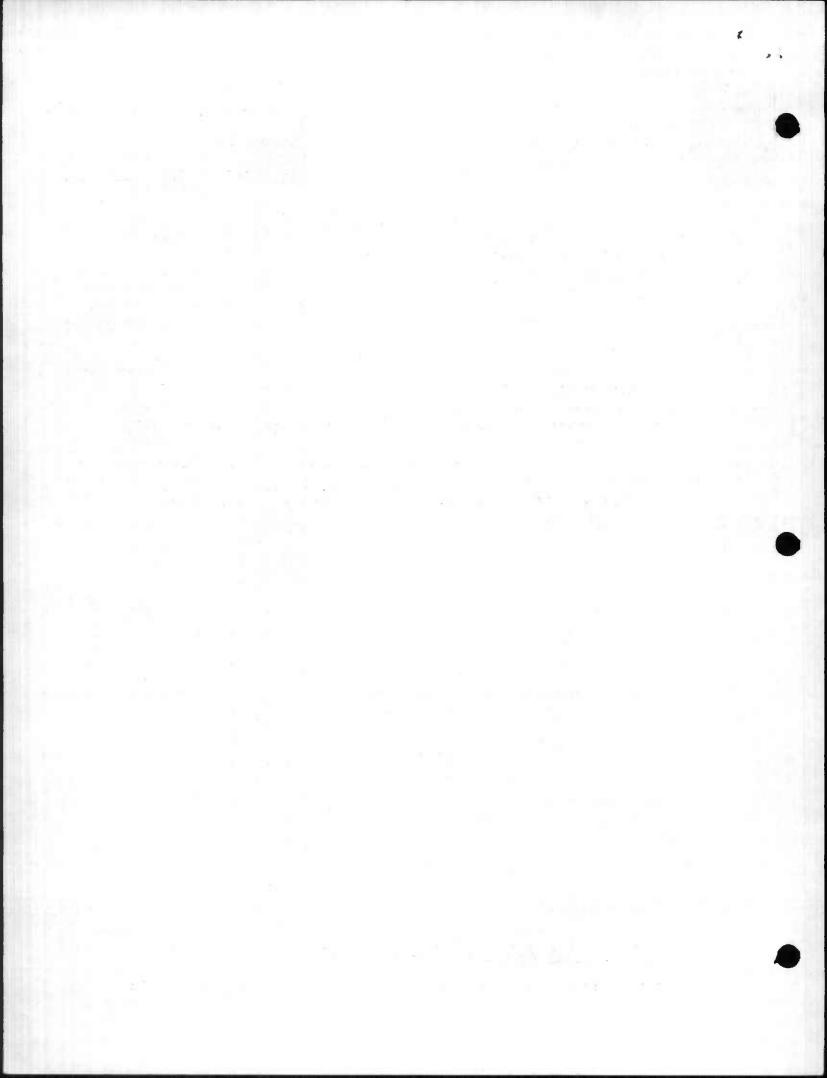
29c. License number

DC 6104

4201 Cathedral Avenue, NW, Washington, DC

29d. Date signed (Month, Dey, Year) January 9, 1998

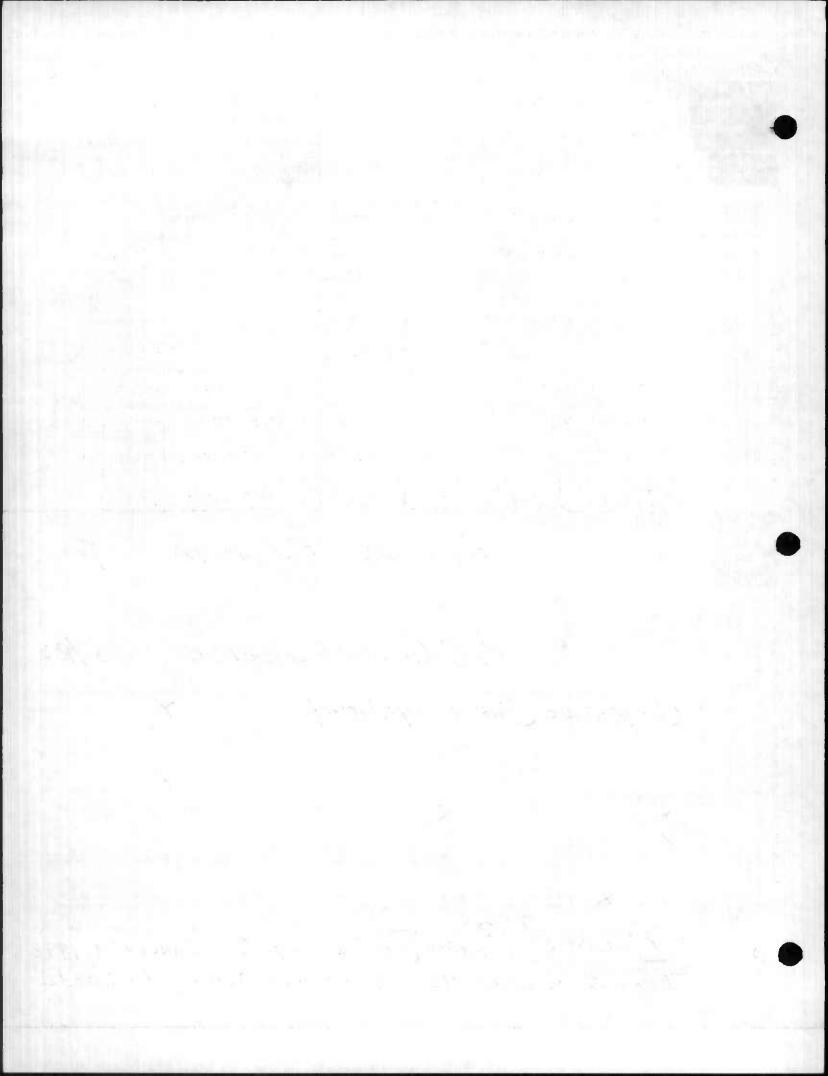
State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. --1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** LAURENCE RAY BOWER 10:23 PM JANUARY 8, 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys 1 □ M 2 □ F 578-18-1310 84 Yrs. Director 6, 1913 MARYLAND Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Manylend neat of Health and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or items 23a or 28e-f show any or other translated event, in Medical Exertive must be notified at any or other traumatic event, in Medical Exertive must be notified at 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Ves 2□No MD Director MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16211 OLD ORCHARD ROAD 20905 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) BYRON ALFRED BOWER 2 HELEN BEATRICE BASSETT 19a. Informent's Neme/Reletionship (Type, Print) (Wife) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) FERN ROYALL BOWER 16211 OLD ORCHARD ROAD, SILVER SPRING, MD 20905 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Depertment of Important: If It any Injury or o 1X Burial 2-□ Cremetion 3 □ Removel from State FT. LINCOLN CEMETERY 1/12/98 4 □ Donation |5 □ Other (Specify) BRENTWOOD, MD 21. Signeture of Funerel Service Laensee Name end Address of Fecility HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD Part. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) **/Medical** Examiner Examiner requires that the death certificate be axecuted physician end the burial-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to for es a consequence of): USB ò Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown þ 24a. Was en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? certificeta hes 1 Yes 2 No 1 TYes Hospital or Attending Physician: 24 hours after deeth. 25. Wes case referred to medical examiner?

Yes 2□ No director Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 1 Inpatient After this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yeer) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Netural 2 Accident 5 Pending 1 Yes 2 No investigation after deetl Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29e. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted.

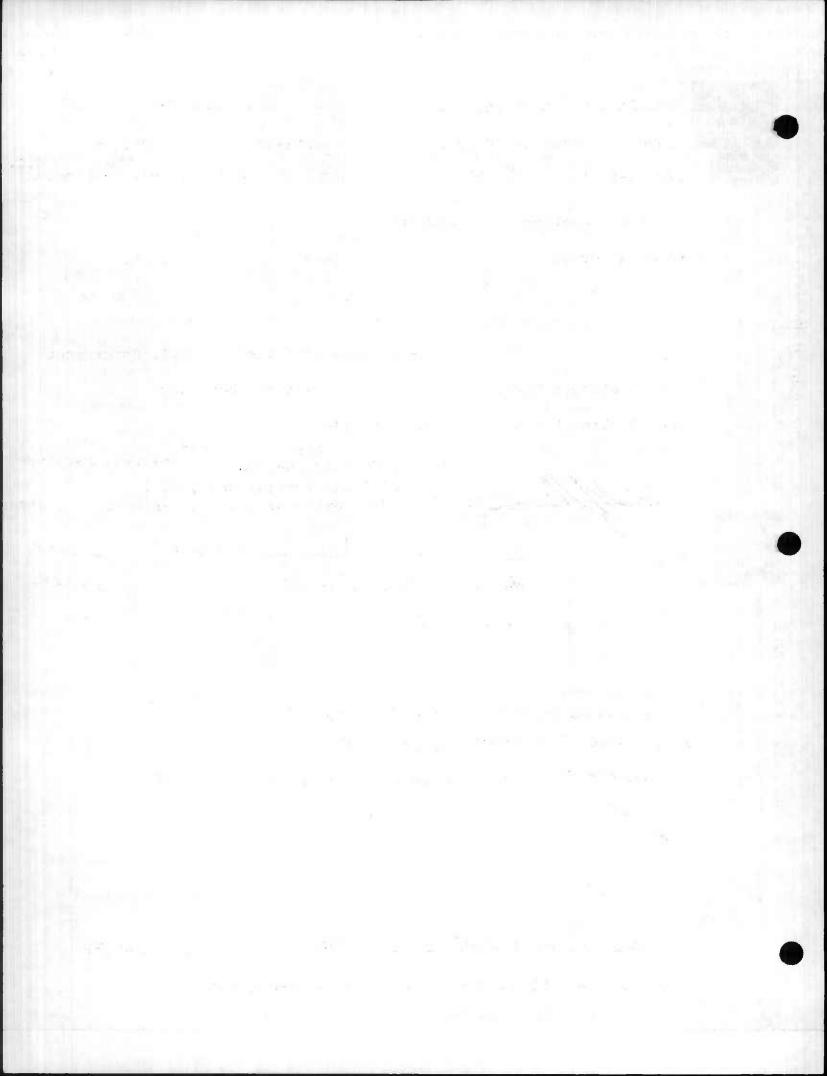
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) DO6406 10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print), DONALD R. LEWIS MD 4006 RT168 OLNEY, MD 26832 31. Dete filed (Month, Day, Year) JAN 13 1998 Registrar



Donald H. Brown, Sr.

			State of Ma		Certificate o			Reg. No. 98	0	1867
Physic /Med		Decedent's Neme (First, Middle, Last) Donald Herbert	Brown,	Sr.				08, ^{Day} 998	Year	3. Time of Deeth 1:10PM
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Funeral		5. Sociel Security Number 6. Sex	2 T E	e (In yrs. last b —	Yrs. H Under 1 Yes		(Month, Da	ry, Year)	9. Birthple Count	ece (State or Foreign
Director		579-12-5304 Usual Residence of Decedent	85)	113.		July	17,191	2 Wa	shington
yland		10a. State 10b. County		10c. City, To	wn or Location				10	d. Inside City Limits
with the Meryland a or 28a-f show	tor	Maryland Charle	s	LaPl	ata					1 ☐ Yes 2X No
or 28	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhet Count	ry?
th wil		4010 Ray Drive			20	646		U.S.	Α.	
oms 23	Funerai	11. Maritel Status 12.	Wes Decedent E Armed Forces?	Ever in U,S.	13. Wes Decedent of	f Hispenic Origin? (Spuben, Mexican, Puerto	pecify Yes or No		e - America k, White, e	
natural", or its		1 Never Married 2 Married	1 ☐ Yes 2 N If Yes, Give		1□ Yes XIN				Whi	
ural.	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dates:							
nat	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16	 Decedent's Usual Occ (Give kind of work don life. DO NOT use reti 	upation ne during most of work	king	16b. Kind of Bu	isiness/Indi	ustry
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D 0	To Be	Ernest Herbert B	rown			Ina Ma	e McDo	naugh		
th and Menta 7 Is marked traumatic ev	-	19a. Informent's Neme/Retationship (Type,		19	b. Mailing Address (Stre			-	State, Zip (Code)
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SE E		20a. Method of Disposition			10:		Date	20c. Location -	City or Tov	vn, State
		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Specify)	lovel from State	Trir	of Disposition (Name or ery, crematory or other p	ial Card	10,19	Wald	orf.	Maryland
Department Important: If any injury or once.		21. Signeture of Funerel Service License		1111	22. Name end Add	Iress of Fecility				7
Depa any i		hall H	м	00668		s Funera		•		
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hysician		shock, or hand lure. List only one of	ceuse on each line	θ.				0		Intervel Between Onset end Deeth
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xaminer		resulting in death) e		Due to (or es	consequence of):					2-3 works
-	ner		ALZH	EIM	consequence of):	EASE			ي ا	5 months
cian and buriel-transit	Examiner	Sequentially list conditions,		Due to (or es	consequence of):			-		
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signe d be	l by	Myocardis/ Z. (a) Arthritis	01		" ' ' '		040 11100		24h Wa	re eutopsy findings
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within 24 hours efter death. To the Funeral Director: A completely filled in by the fo	cat	2 Accident investigation 3 Suicide 6 Could not be	00 - Di (1)	***		☐ Yes 2☐ No	006 Leastien /	Chronit and Missah	as as Owel	Courte Mumb
Direc In by	Certification:	4 Homicide determined	building, etc.	ry - At nome, . <i>(Specify)</i>	arm, street, fectory, offic	10	City or To	Street end Numb wn, State)	er or Hurai	Houte Number,
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Fun Fun etely	Medicai		On the basis of a	examination e	e, deeth occurred et the nd/or investigation, in my	oplnion, deeth occur	red at the time,	date end plece,	and due to	the ceuse(s)
ithin of the	Me	29b. Signature end title of cartifier	ond mornior state		29c. Lice	nse number		29d. Dete signed	(Month, E	Dey, Year)
s ⊢ ö) amelio C.	deles	le .	D-161	.60		01-0		
				9,				01-0	_ /	o
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St	ato	Aurelio De la Paz, MD 128 31. Dete filed (Month, Day, Year)		West P.U.	DUX 123U LA F	iala, rarylar	10 20046			
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ficate of Death	Reg. No.	0	U	1	U	U	

TODD T. BI			nd / Department of Certificate o		Re	g. No.	01868
Physician	Decedent's Name (First, Middle, L				2. Date of Death Month	Day	3. Time of Death
/Medical	TODO TINELL B	ELL		1 0 0 T	JANUARY		998 1545PM
Examiner	4a Facility Name (If not institution, g	iva street and number)		4b. City, Lown, or	Location of Death	4c. County	of Death
1411	2122 DUCHY COUR 5. Social Security Number 6.		. last birthday) If Under 1 Ya	WALDORF ar If Under 24 Hrs	s. 8. Date of Birth	CHARL	ES COUNTY
Funeral Director	219-11-9454 Usuel Residence of Decedent	1⊠M 2□F 29	Yrs. Months Day		(Month, Day,	, 1968	9. Birthplaca (State or Foreign Country) Maryland
yland	10a. State 10b. County	10c. C	ity, Town or Location				10d. Insida City Limits
e Men	Maryland Char	les	Waldorf				1 ☐ Yas 2X No
or 28	10e. Street and Number		10f. Zip Code		10		What Country?
eth w	2122 Duchy Court		206			USA	
items items	11. Marital Status	12. Was Decedent Ever in I	J,S. 13. Was Dacedent of If Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pua	Specify Yas or No- rto Rican, etc.)		e - American Indian, ck, White, etc.
d 21215-0020 Iliad within 72 hours efter deeth with the Meryland hygiene. The Trautral', or items 23s or 28s-1 show but, the Medical Examination must be notified at a Completed by Filmeral Director.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🔍 N	No Specify:		Specify	DIACK
ind 21215-0 be filed within 72 ho tal Hygiene, dother than "natura event, the fed call	15. Decedent's I (Specify only highest g	Education rade complatad)	16a. Decedent's Usual Occ (Give kind of work do. life. DO NOT use ref	cupation ne during most of wo	orking 1	6b. Kind of Bu	usiness/Industry
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Maryland d 2 should be flie fifth end whental Hy r7 is marked othe trsumatic event	Harold Ellington	Flournov		Mary [Delores Be	11	
should and Men marks umaric	19e. Informant's Name/Relationship		19b. Mailing Address (Stre				State, Zip Code)
end 2 end 2 selth e n 27 is	Lynette A. Bell	- Wife	2122 Duchy (Ct., Waldo	orf, MD 20	602	
Ore of He	20a. Method of Disposition 1 \(\sum_{\text{Rurial}} \text{Purial} \) 2 \(\sum_{\text{Cramation}} \) 3 \(4 \sum_{\text{Donation}} \) 5 \(\sum_{\text{Other}} \) Other (Spec	Removal from State	Place of Disposition (Name of cemetery, crematory or other place) Surrection Cen	place)			City or Town, Stata Maryland
Baltimoperation of the sand important: I sand injury of the sand injur	21. Signature of Funeral Service Lice	ensae ·	22. Name and Ad	dress of Facility			
Physicían /Medical Examiner	Shannon W. R 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that ceused the dea y one cause on each line.	ath. Do not enter the mode of a slight shot (or as a consequence of):			20004 = st,	Approximata Intervel Between Onset and Death
8760, sete be executed physician and the buriel-trensit		b	(or es a consequence of):				
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Box 68760, death certificate be executed a strending physician end ad for use as the buriel-trensit	Cause (Disease or Injury that initiated events rasulting in death) Last	cDue to (or as a consequence of):				
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P.O. BOX 6 at the death certific d by the attending stached for use es	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying couse	given in Part I.	23b. Did tol	bacco use co	ntribute to the cause of death?
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Division To the Hospital or Attending Is within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Medical Certification		rhysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred at the ation and/or Investigation, in m	e time, date and place by opinton, death occ	e, and due to the ca	use(s) end m	enner as stated.
Nithin Fo the comple			29c. Llc	ansa numbar	25	d. Date signe	ed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

Donald G. Wright M.D.

Nonald Sharight MD

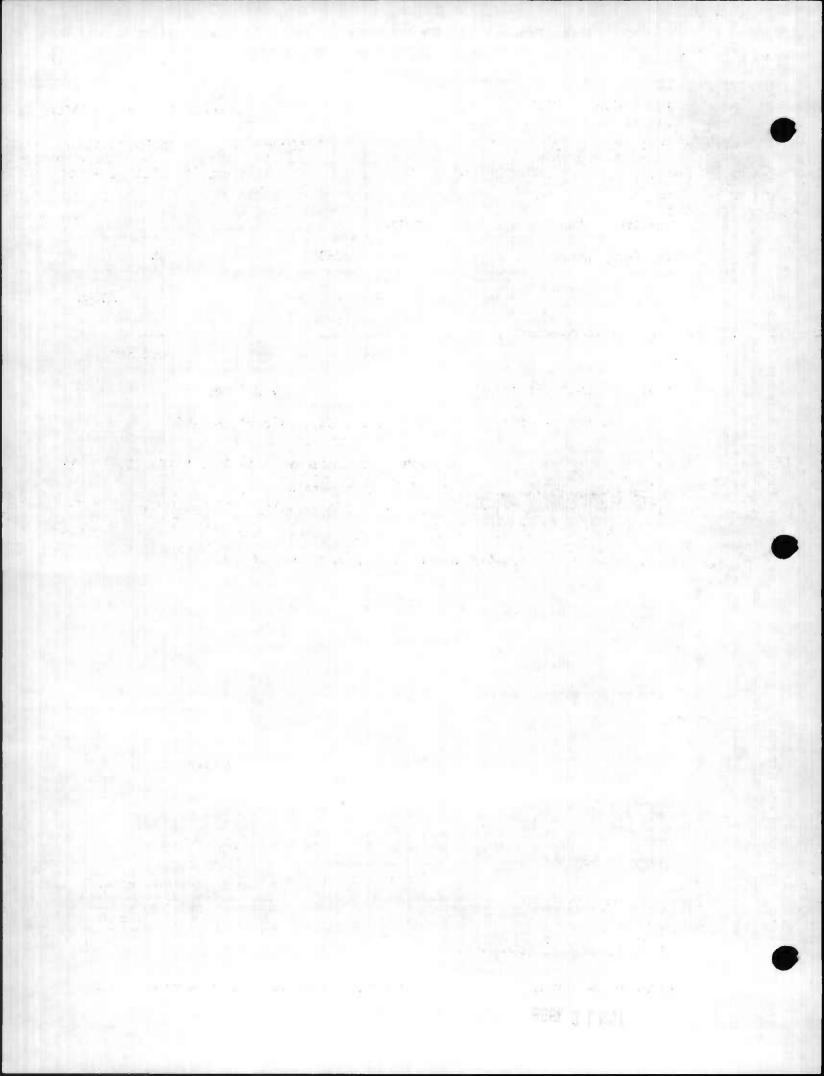
111 Penn Street, Baltimore, Maryland 21201

JANUARY 12, 1998

O.C.M.E.

State Registrar

31. Date filed (Month, Day, Yeer) JAN 1 6 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 1:00 PM Clara Barry "al /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Mechanicsville St. Mary's 28625 Hancock Drive | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | April 22, 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpleca (State or Foreign Country) **Funeral** 1 M 2 F 577-34-1095 69 Yrs 1928 Washington DC Director Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location ages 1 and 2 should be filed within 72 hours efter death with the Merylen rt of Heelith and Mental Hyglene. It of Heelith and Mental Hyglene. If them 27 is marked other than "natural; or ttems 23a or 28a-f show or fother traumatic event, the Medical Experience mant be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland St. Mary's Mechanicsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 28625 Hancock Drive 20659 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 1 Never Merried AM Married Baltimore, Maryland 21215-0020 1 ☐ Yes 200No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 18b. Kind of Business/Industry Of America Elementary/Secondary (0-12) Coilege (1-4or 5+) Secretary Air Transport Association 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William H. McColley Anna H. Johnson 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James W. Barry Sr. 28625 Hancock Drive, Mechanicsville, Md 20659 of Disposition (Name of Dete 20c. Location - City or Town, Stete 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition permit. Peges 1 Department of H Important: If Iter any injury or oth Lee Crematory Jan 12, 1998 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Funeral Home, Inc. 21. Signature of Funeral Service Lie 22. Name end Address of Fecility 6633 Old Alexandria Ferry Rd Clinton, MD 20735 ack 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervei Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest and Due to (or as a consequence of) physician s the buriel-Physician/Medical Due to (or as a consequence of): ettending Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by (2 No 3 Probably 4 Unknown 2 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed peen page 2 s 2 No certificate 1 Tyes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Certifying Phyeicien: To the best of my knowledge, death occurred et the time, dete end placa, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

State

Medicai

29e. Certifier

29b. Signeture and the of certifier,

Box 68760

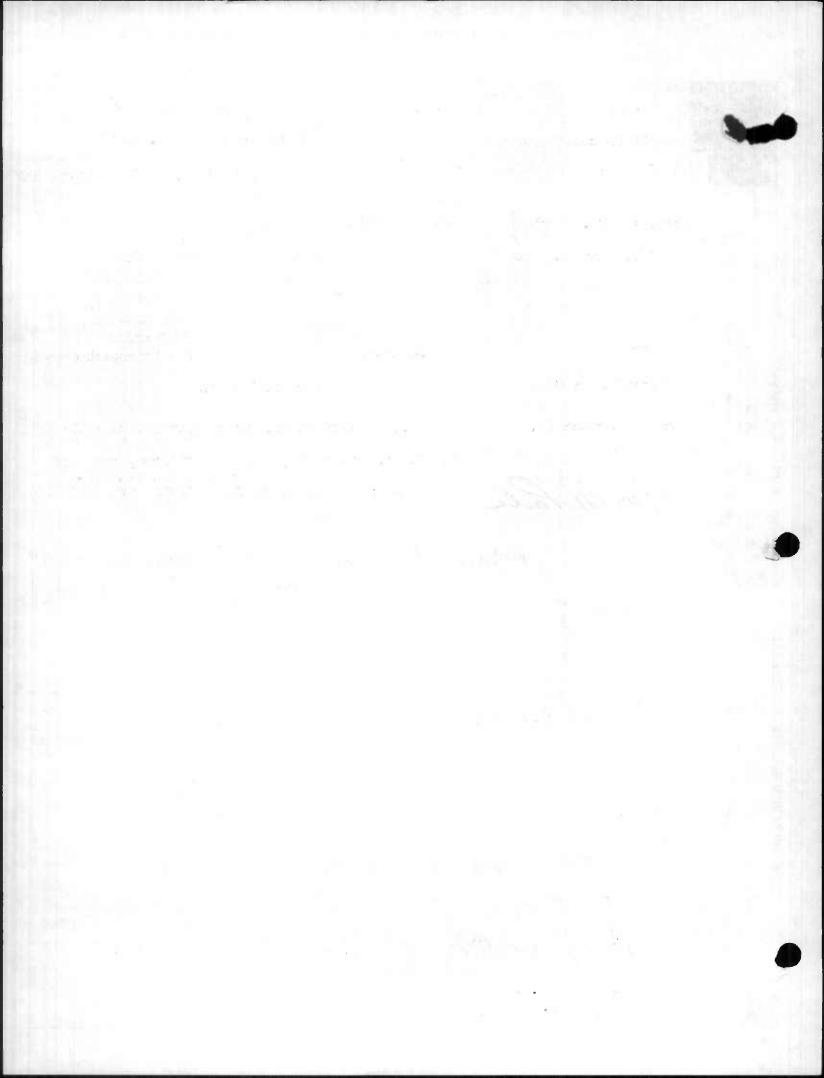
P.O.

Division of Vital Records.

Mary L. Kramer M.D. 32. Registrar's Signature JAN 1 4 1998

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Registrar



State of Maryland / Department of Health and Mental Hygiene

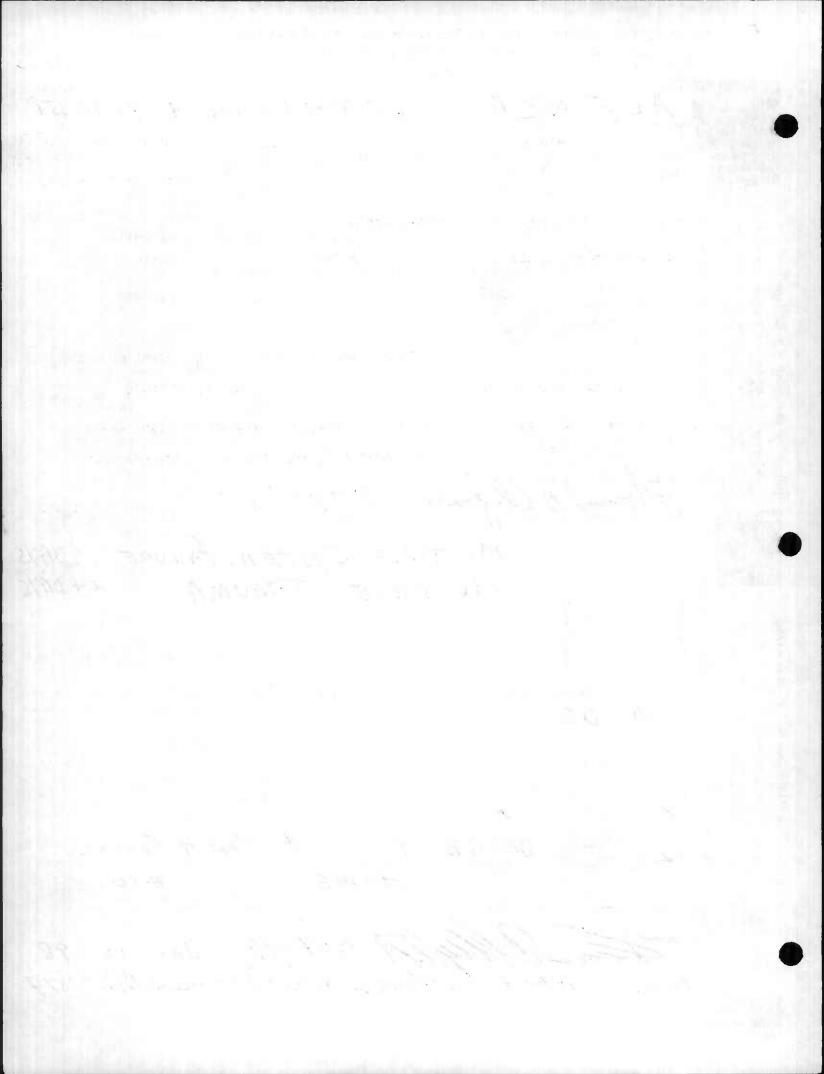
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 01 VAN /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Deys 33 Yrs. Director 243 29 9093 July 27,1964 Edenton, N.C. Usual Residence of Decedent the Maryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Ves 2 □ No Director Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23a 1511 November Circle 20904 Funerai United States filed within 72 hours efter death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ⁴ Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0020 ŏ by 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Black Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within ent of Health end Mentel Hygiene. nnt: If item 27 is marked other than inty or other traumatic event, the Mary or other event, the Mary or other traumatic event, the Mary or other traumatic event, the Mary or other traumatic event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other event, the Mary or other even Elementary/Secondary (0-12) College (1-4or 5+) Rehabilitation Aide Nursing Home Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Louis Brothers Jr. Volivia Elliott 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Katie Askew (Sister) 7121 - 9th St., N.W., Washington, D.C. 20012 Baltimore, I 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. Beaver Hill Cemetery 1/15/98 4 ☐ Donetion, 5 ☐ Other (Specify) Edenton, N.C. 21. Signature of Funeral Service Licansee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that our ed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate

Approximate **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Box 68760, ettending physicien Physician/Medicai Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Piece of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 this funeral 27. Menner of Death Date of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending Investigation 1 Natural To the Hospital or Attendit within 24 hours efter death.

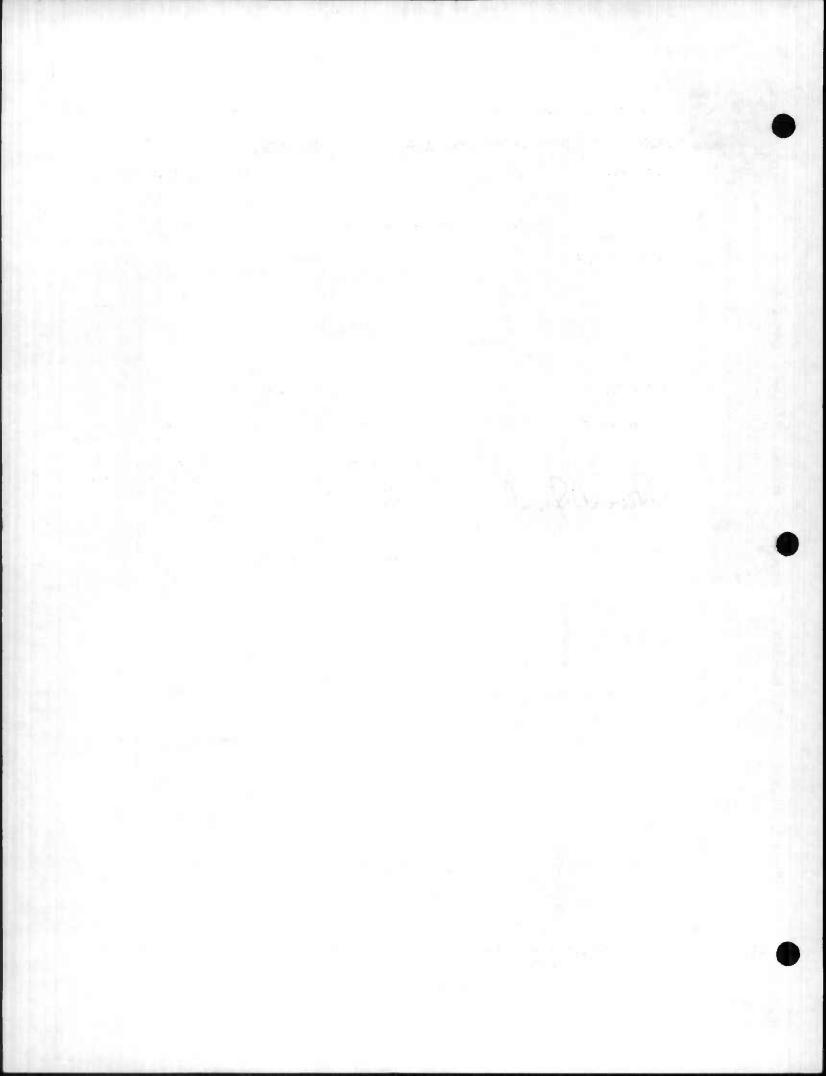
To the Funeral Director: A completely filled in by the f 1798 1 Yes 2 No FALL)EC 2 Accident LOORS 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homloide HOME 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29b. Signature end tills of e 10215 FERNWOOD State chia Davidson Registrar



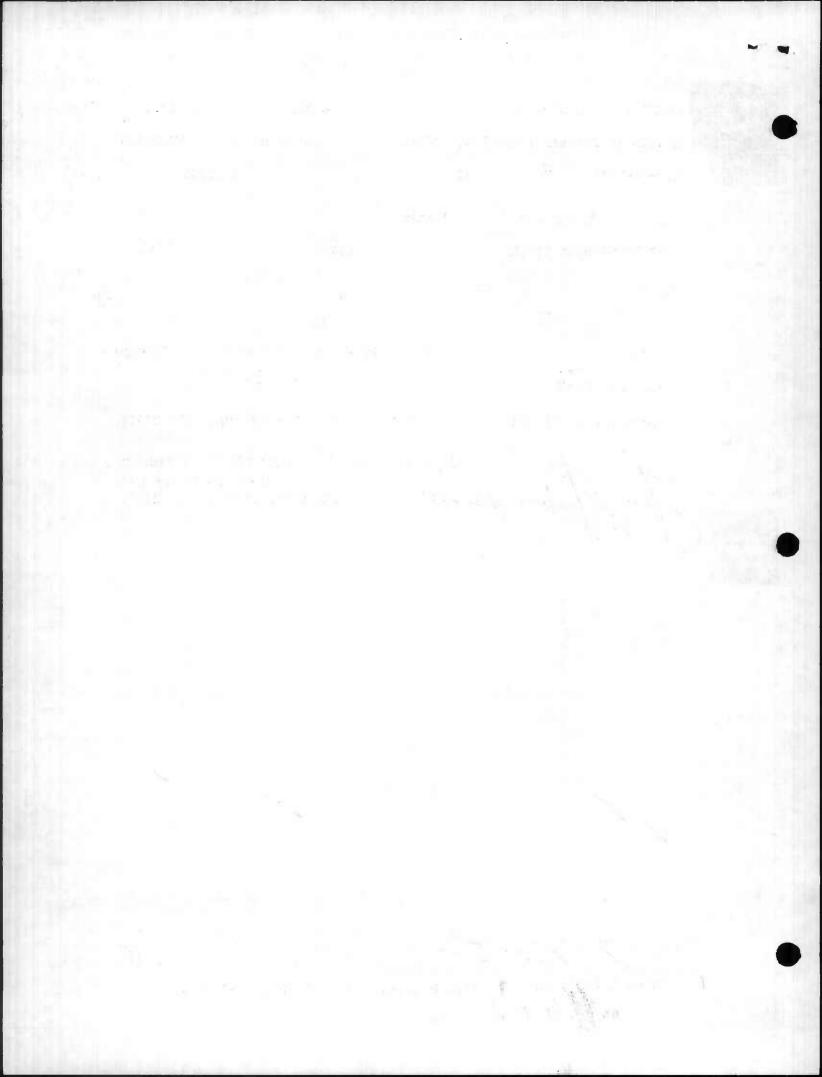
State of Maryland / Department of Health and Mental Hygiene

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10		19a. informant's Name/Reletionshi Helen Poole		- 1							r, City or Town,		le)
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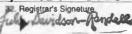
State of Maryland / Department of Health and Mental Hygiene 8 0 1 8 7 2

				Ce	rtificate o	f Death		Reg.	No.	UI	016	
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		SALISBURY CENTER	: GENESIS ELDE	ERCARE		SALISE	BURY, MD	. W	ICOMI	CO		
Funera Directo		218-04-7957	Sex 7. Aga (In yrs 30	s. last birthday) Yrs.	Months Day		24 Hrs. 8. Da Min. 9	te of Birth onth, Day, Ye 23/67	ar)	9. Birthp Coun	lace (State or I	Foreign
and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					T	0d. inside City	Limite
he Maryl 8a-f sho	ector	MD Worce		Berlin							1 ☐ Yes 2	
23a or	Funeral Director	10e. Street end Number 104 Martinique	Circle		10f. Zip Code 218			10g.	Citizen of V US/		try?	
Z 1 Z 1 3-UUZU d within 72 hours after death with the Maryland giena. r than "natural", or frems 23s or 28s-f show the Medical Examine must be notified at	by	11. Marital Status 12€ Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Datas:	U,S. 13.	Was Decedent of If Yes, specify Cu			etc.)		a - Americ ck, White, Wh	etc.	
4 within 72 hours Jiena "natural", Ins Moderal E.	Completed	15. Decedent's (Specify only highest g	Education rada completed)	16a. Dece	dent's Usual Occ	upation e during mos	st of working	16b	. Kind of Bu	usiness/Inc	dustry	
within ena. than	n du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)	20 1 1 22		Cons	+ 1011.04	ion	
		12		Heav	y Equip	-					1011	
Manta Marked arked	To Be	17. Father's Name (First, Middle, La. Dean Lee Beall	st)				er's Name (First, atherine			16)		
CENE		19a. Informant's Neme/Reletionship Catherine Beal			ng Address (Stre						Code)	
mit. Pages 1 an partment of Heal portant: If Item 2		20a. Method of Disposition Burial 2 Xremetion 3	☐Removal from State	cemetery, cre	osition (Name of matory or other p		Date		Location -			
permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Co		•	nlopen C 2. Nama and Add			ge Fu				
00580	1	Jane XI/Lin	les Moor	ay	108 Wil	lliam S	t. Berli	n, MD	218	311		
Physiciar /Medica Examine	1	Sa. Farti. Entermit disease, or co mock, or hear fasturer. List on an ediata Cause (Final disease or condition resulting in death)	a. A11			ying, such as	cardiac of respi	atory errest,			Approximete Interval Betwee Onsat and De	en ath
₽ #	iner		b. Cont	ages	Rec	es				6		
execute in and ial-trans	Examiner	Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying		(or es a consec	quence of):						,	
aath cartificate be executed attending physician and I for use as the burial-transit	edicai	Ceuse (Disease or injury that initiated events resulting in death) Last	c. Due to (or as e consec	quence of):							
carti nding use a	≥		d									
. 0 0 0	Physician	Part II. Other eignificent conditione	contributing to death but not re	sulting In tha u	inderlying cause	given in Pert	l. 23	3b. Did tobac	CO USE COI	ntribute to	the cause of	death?
requires that the death ca seen signed by the attendi	by Phy							1 Yes	2□ No	3 ☐ Prot	oably 4□Ur	nknowr
2 s t	Completed						24	a. Was en au performed		ava	ere eutopsy fine allabla prior to appletion of cau death?	
	mo.	St. Times						1□ Yas	2 No	10	Yes 2□N	0
	Be	25. Was case referred to medical				26. Place	e of Death (Chec	k only one)				
. S . 0 0	To	examinar? 1 Yes 2 No	Hospitel: 1 Inpatient 20	☐ ER/Outpatie	nt 3 DOA	Whor	ursing Home 5		6 □Oth	er (Specify	()	
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors of the funeral directors.		27. Manner of Death 1 Noturel 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time o injury	W		28d. De	escriba how in				
or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Injury - At building, etc. (Spec	nome, ferm, st	reet, factory, offic	8	28f. Lo Cit	cation (Street y or Town, St	t and Numb tate)	er or Rura	l Route Numbe	W,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edicai C	29a. Certifier 1 ☐ Certifying F (Check only one)	hysician: To the best of my kn miner: On the basis of examin end manner stated.	owledge, deat ation end/or In	h occurred at the vestigation, in my	time, date en opinion, dea	d place, and due	to the cause e time, dete	e(s) and me	enner as st end due to	eted. the ceuse(s)	
vithin o the	Me	29b. Signeture and title of certifier	one manner states.		29c. Lice	nse number		29d.	Dete signed	d (Month, I	Day, Year)	
- > - O		100	HALL			7 8	719		Von	m		
		30. Name end eddress of person who	completed cause of death (Its	m 23e) /Tuno	Print)	0/	1/	1	19/	8		
	1	William Robins,	MD			CALTO	DITIDAY MET	2100	1			
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	WAY DR.	SALIS	BUKY, ML	ZTSO2	±			
Regis		JAN 0 9 19	198 Julio Javi	dson-Range	delle							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

Physici /Medic		1. Decedent's Name (First, Mid	die, Last)					2. Date of Deati		Varr	3. Time of Deeth
		VIRG:	INIA S.		BURNS			JAN.	Day	Year L998	10:15AM
Examir		4e. Fecility Name (If not instituti	ion, give street end numb	er)			4b. City, Town, or		4c. County		
					INGTON		KENSIN		MO	ONTGO	MERY
Funeral Director		5. Social Security Number 070-36-9559 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs 88	: last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, NOV. 14	Yeer) 1909	9. Birthpla Countr NEW	ce (Stete or Foreign y) YORK
M ==		10e. State 10b. Coun	ty	10c. C	ity, Town or Lo	cation				100	d. Inside City Limits
al', or items 23a or 28a-f show Evainings mant be notified at	to	MD. MONTO	OMERY		F	ENSINGT	ON				1X Yes 2□No
1 28	Director	10e. Street end Number			_	10f. Zip Code		10	g. Citizen of \	What Countr	y?
238		3000 McCOM	AS AVE.				20895		U.	S.A.	
	Funeral	11. Marital Status	12. Was Decede Armed Force			Vas Decedent of	Hispenic Origin? (Soan, Mexican, Puert	pecify Yes or No-	14. Rac	e - Americe	
edical Examine	by	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	ırrled 1 ☐ Yes 2]	No No		Yes 21 No		o rican, etc.)	Specify	ck, White, et	c.
legical	Completed	15. Decede	ent's Educetion est grede completed)		16a. Deced	lent's Usual Occu	pation during most of wor	tkina 1	6b. Kind of B	usiness/Indu	istry
3	npie.	Elementary/Secondary (0-12)		or 5+)	life. L	O NOT use retire	9d)	Kiirg			
1, 114	S	47 Fabrica Manager (First Addate)	4		F	HOMEMAKE			CA.		E
tic event,	To Be	17. Fether's Name (First, Middle JOHN	SINGLETON					ne (First, Middle, M NNA	schro		
traumatic		19a. Informant's Name/Relation			19b. Mailin	g Address (Stree	t end Number or Ru	ral Route Number,	City or Town,	Stete, Zip C	Code)
other		WILLIAM BURNS	S/SON				N DR., WH	EATON, MI	2090)2	
ō		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (3 ☐Removal from Sta	te	cemetery, crem	sition (Name of netory or other ple CREMATO)		Date 2 1/12/98	Oc. Location -		
any Injury once.		21. Signature of Funeral Service		011		Name and Addr		2/22/30	7 00 A 737 C	و ستام	
any l		1/11/11/	muley of	FUNERAL H				RING. MD.			
g physician and es the buriel-transit	Examiner	resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury	b		or as a consequ	,				1	
s the buri	edicai	Cause (Diseese or Injury that Initiated events resulting in death) Last	С.	Due to (d	or as e consequ	uence of):					
e esn	and a		d							!	
thed for	icia	Part II. Other significant condit	lone contributing to death	but not res	cuiting in the un	deriving cause of	ven in Part I	23h Did tok	0000 1100 001	ntribute to t	he cause of death?
be detached for use	y Physician/N	RENAL FAILU					ven in Part I.		8 2 No		bly 4 Unknown
2 should be	Completed by							24a. Wes en		avail	e eutopsy findings able prior to pletion ol cause
aga 2	Eo							1 ☐ Yes	2 X No		Yes 2□ No
	Bec	25. Wes cese referred to medical	əl				26. Place of Dee	th (Check only one		, , ,	2010
direc	To	examiner?	Hospital: 1 Inpa	tient 2	ER/Outpatient	3□ DOA Ot	hor	ome 5 Resider		er (Specify)	
funeral		27. Manner of Death 1 Natural 5 ☐ Pendi	ng 28a. Date of in (Month, Ligation	ijury Dey Year)	28b. Time of Injury	M 28c. Inju	ryat rk? IYes 2 □ No	28d. Describe how	v Injury occur	red	
ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, stre	et, factory, office		281. Location (Stre City or Town,		er or Rural F	Route Number,
# # # # # # # # # # # # # # # # # # #	edicai (29a. Certifler (Check only one) Certifyi 2 Medical	ng Physician: To the besi Examiner: On the basis end manner	or examina	owledge, deeth ation and/or inve	occurred at the ti estigation, in my	me, date and place, opinion, death occur	, and due to the cer rred at the time, da	use(s) and ma e end place, a	nner es stet and due to th	ed. ne ceuse(s)
etel	Me	29b. Signature end title of certific				29c. Licens	se number	29	d. Date signed	d (Month, De	ey, Year)
completel	- 1										
To the Funeral Director: After this completely filled in by the funeral		1 Meta c	Theyel	M			8944		JAN.	9,	1998
To the Funeral Completely filled		30. Name and eddress of person MARTIN C. S				Print)	8944 UT AVE.,	KENSIN			



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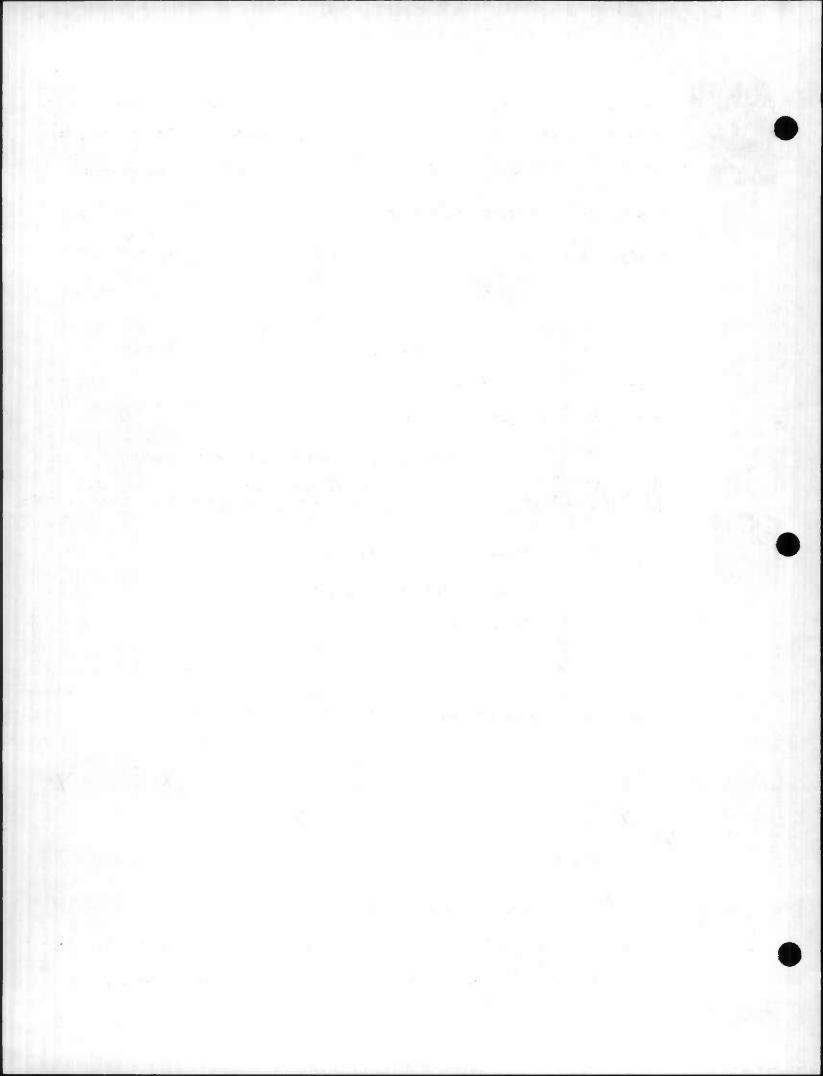
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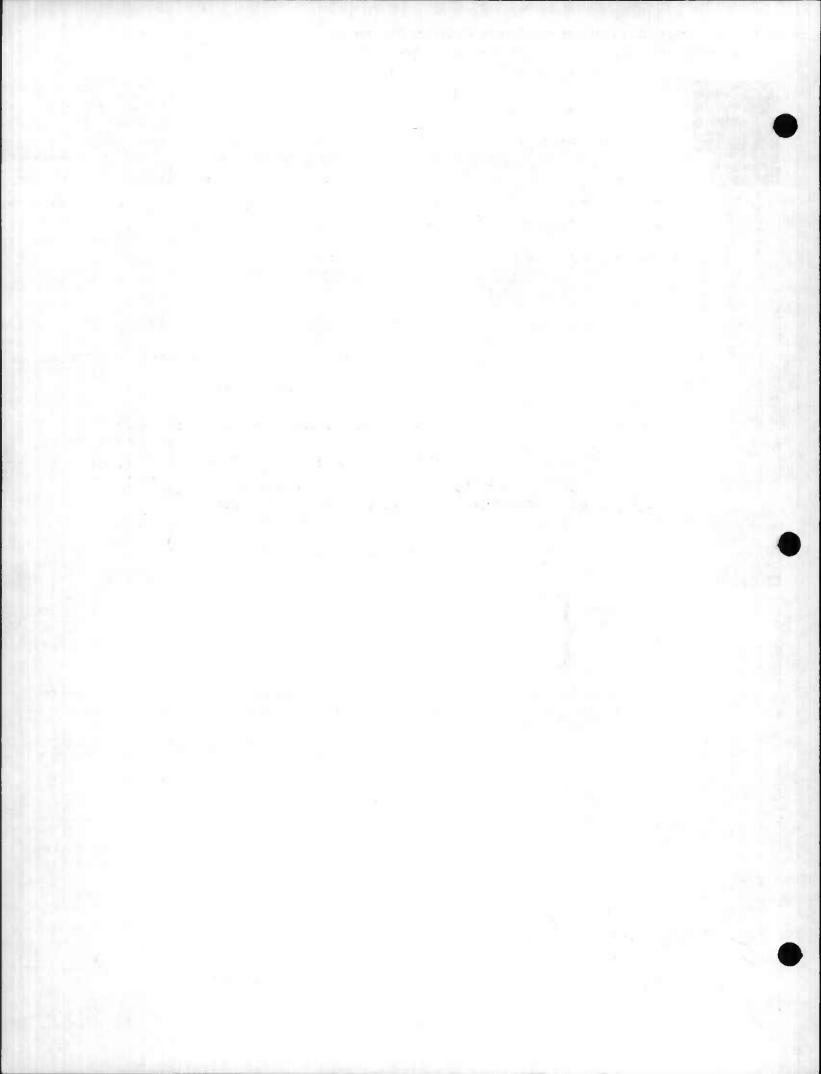
State of Maryland / Department of Health and Mental Hygiene 01874

							Cert	rificate	of	Death			Reg. No.	U	10/4
Physic	ian	1. Decedent's Name (First, Katherine	Middle, La Z •		inger							2. Date of D	eath ry Pay	1998	3. Tim f th 9: 5 •
/Medi Exami		4a. Facility Name (If not inst	itution, giv	ve street and n	um <i>ber)</i>					4b. City, To Gre	wn, or Le	ocation of Dee			orge's
Funeral Director		5. Sociel Security Number 577–28–5662		Sex 1 □ M XX F	7. Age (In yrs. last bir 94	thday) Yrs.	If Under 1 Months	Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D June 2	irth av. Year 0, 1903	9. Birthp	place (State or Foreign
- D		Usuel Residence of Decede													
e Maryla Ba-f ehov	ctor	Maryland Pr		George		oc. City, Tow Greent		ation							10d. Inside City Limits ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑
th with th	al Dire	10e. Street end Number 22 Ridge Roa	ad, A	Apt.#10	4			10f. Zip 0	ode 077	0			10g. Citizen of Unite		,
72 hours efter death with the Maryland 72 hours efter death with the Maryland hatural', or items 23a or 28s-1 show lical Examinet must be notified at	by Funer	11. Maritel Stetus 1 □ Never Married 2 □ 3 ▼ Widowed 4 □ Dive		12. Wes Dec Armed F 1 Yes If Yes, G Year or	orces?	er in U,S.		es Decede Yes, specif		lispanic Ori an, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra Bla Specia	ca - Americ ack, White, ity:	
within ane. then	Completed by Funeral Director	15. Dec (Specify only I Elementary/Secondary (0		ade completed) (1-4or 5+)		(Give ki	ent's Usual ind of work O NOT use aker	Occup done retired	ation during mos	t of work	ing	16b. Kind of I		dustry
nd 2 should be filed ifth end Mental Hygis 27 is marked other traumatic evant,	To Be C	17. Father's Name (First, Mi	ddle, Last	")	Zarı	JOW					er's Nem	e (First, Middle	e, Maiden Suma		bur
1 and 2 should Health end Men em 27 ie marke	ŀ	19a. Informant's Name/Rela Lucille M. W			ter)	19b	. Mailing	Address (Street 10	and Numbe	er or Rur	al Route Numb	ber, City or Town	n, State, Zip	Code)
permit. Pages 1 ar Department of Hea mportant: If Item 3 Iny Injury or other		20a. Method of Disposition 1 ☐ Burial 2 XXrema 4 ☐ Donation 5 ☐ Oth				20b. Placa of cemeter Metro	ry, crema	atory or oth	er plac	natory	1/	Date 12/1998	20c. Location Alexan		own, State Virginia
permit. Pages Department of Important: If its any injury or o		21. Signifure of Funeral Se	. B	rawar	olt.		Do	nald	٧.		vard		al Home		A. rland 2070
Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Finel disease or condition resulting in death)	se, er com List only		e Lei	e death. Do not be to (or as a contract of the total or as a contract of the total or as a contract or as a	er 1	obe p				or respiratory	arrest,	4	Approximate Interval Between Onset and Death
D #5	lner			Seve		rthrit			bi1	ity					6 mos.
e execute ian end uniel-trans	I Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	J	agin		e to (or as a dement:		enca of):							2 years
eath certificate be executed ettending physician end for use as the bunel-transit	/Medical	that initiated events resulting in death) Last	J	d	Du	e to (or as a c	conseque	ence of):							
het the d od by the detached	y Physician	Part II. Other significant con							use giv	ren in Part i			Yes 20 No		o the cause of death? bably 4 🗆 Unknown
requires been sign	Completed by												s en eutopsy formed?	ev	ere eutopsy findings eileble prior to impletion of cause death?
The law ate hes page 2	Com											1 🗆	Yes 2 No		☐ Yes 2 No
ysician: The	Be	25. Wes case referred to me examiner?	edical	Manadada					100		of Deat	h (Check only	one)		
tending Physician: leeth. tor: After this certific the funeral director,	tion: To		ending vestigatio	28a. Date (Mor	Inpatient of Injury oth, Day Y	28b. 1	tpetient Fime of njury	3 DOA	c. Injur Wor	y at			how Injury occu		(y)
frec frec n by	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	e 28e. Plac	a of Injury ling, etc. (- At home, fa Specify)	rm, stree				-	28f. Location City or To	(Street and Num own, State)	ber or Rur	al Route Number,
To the Hospital or within 24 hours efter To the Funeral Dir I completely filled in	Medical C	29e. Certifier (Check only one)	tifying Ph licat Exar	niner: On the b	e best of n pasis of ex oner stated	aminetion and	, death o	occurred at estigetion, l	the tir	ne, date an pinion, dea	d place, th occur	end due to the red at the time	cause(s) end n , date and placa	nanner es s , end due t	tated. o the ceuse(s)
vithir Voithir Comp	M	29b. Signature end title of ce	ertifier he	most	1				Licens	e number			29d. Date sign		Day, Year)
		30. Name end address of pe Leela Kris	rson who	completed cau	se of deat	th (Item 23a) ((Type, P	rint) polis	Ro	ad, #	301	Lanham	n, Maryl	and 2	0706
Sta Registi		31. Date filed (Month, Day, 1	5 19	98 32.	egistrar's	Signature	Panda	200							

DHMH 16 Rev 6/95



		1. Decedent's Neme (/	First, Middle. La	est)			Timoatt	COII	Death	2. Deta of De	Reg. No.		3. Time o	of Death
siciar	n		rly Mae							Month January	Dey	Year Q.?		
edica mine	-	4a. Facility Neme (If no			nber)				4b. City, Town, o	Location of Deat			1:20	PM
minei	at .	Holy Cro							Silver S				2017	
ral		5. Social Security Num			7. Aga (In yrs	. last birthday)) If Under	1 Yaar	If Undar 24 Hr	s. 8. Data of Bi	rth			or Foreig
tor	-	579-38-237 Usuei Residence of De	3	1□M 2□F	69	Yrs.	Months	Deys	Hours Mir	i. (Month, Di	9, Year) 4, 1928	Wash	ingto	n, D
4		10a. Stata 10	0b. County		10c. C	ity, Town or Lo	ocation					10	Od. Inside C	ity Limits
1	010	MD	Montgo	mery	1	Rockvil	lle						1 🗆 Yes	2 ☐ No
l'e	Funeral Director	10e. Streef and Number	er				10f. Zip	Code			10g. Citizen of	Whet Coun	fry?	
9		11318 Sch	uylkill	Road				20	852		U	SA		
9	ne l	11. Maritel Status		12. Was Deced	dent Ever in U	J,S. 13.	Was Deced	denf of H	ispenic Origin? (Specify Yas or Norto Rican, etc.)	0- 14. Red			
hv E	2	1 ☐ Never Merried 3 ☐ Widowed 4 4	_	1 Yas If Yes, Give Yeer or Da	2 🔀 No		1□Yes 2		Specify:	no moun, otoly	Specify	year 98 1 r of Death t gome ry 9. Birthplaca (Country) Washing 10d. Install 11c. Whet Counfry? SA se - American Indick, White, etc. White etc. White etc. White etc. White authorise was Funer West Appropriate of death? 1 Yes The reference of the contribute to the contribute to the contribute of death? 1 Yes The reference of the contribute to the contribute to the contribute to the contribute to the contribute of death? 1 Yes		
1	Del	15	. Decedent's Ed	ducetion		16a. Dece	dent's Usua	I Occup	ation	a al-la a	16b. Kind of B	usiness/ind	lustry	
9	Completed	Elementary/Seconde	only highest gra ery (0-12)	Coilege (1-	4or 5+)	life.	DO NOT us	se retired	during most of w	orking				
	0	12				A	Analys	st			Federal	Gove	rnmen	t
8		17. Father's Neme (Fir.	st, Middle, Last,)					18. Mother's Na	ame (First, Middle	, Meiden Suman	ne)		
3	0	Howard Hur	d						Paulin	e Unknov	vn			
		19e. Informent's Name	AReietionship (Type, Print)		19b. Meili	ing Address	(Street	and Number or F	Rural Route Numb	oute Number, City or Town, Stete		Code)	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Commissed by Eugene Disease.		Paula Ber	ry (daughter						unt Airy	, MD 2	1771		
	1	20e. Mathod of Disposi 1 ☐ Buriei 2 ☐ C		Domouei from C	20b.	Piece of Dispo cemetery, crer	osition (Nem	ne of ther plea	ce)	Date	20c. Location -	City or To	wn, Steta	
		4 Donetion 5			Par	klawn	Memor:	ial	Park	1/17/98	Rockvil	le, M	D	
		21. Signatura of Funer	al Service Licar	nsaa	11	2 22	2. Nama and	d Addre	ss of Fecility F	rancis .	. Colli	ns Fu	neral	
8		1 M	mt	1	11	H	Home,	Inc	. 500 U	niversit	y Blvd.	West		
	1	23a. Part 1. Enter the	diseesa, or com	plications that ca	used the dee	1 5	strver	_ 5p.	ring, MI	20901				
cian dical diner			silule. List only	one cause on ee						ac or raspiratory a	ırrast,	1	Intervel Be	tween
	liner	immediate Ceuse (Findiseese or condition resulting in daeth)		e.	loni		To		og, such as cerdi	ec or raspiratory a	irrast,		Intervel Be	tween
eal ler lex		diseese or condition resulting in daeth)	ai	e	UN V	nary	Zov quence of):			ec or raspiratory a	irrast,		Intervel Be	tween
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daath 3. Time of Deeth **Physician** JANUARY 7,1998 MAE SADIE BROWN 11:45am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth A Facility Name (if not inetitution give street and number) **Examiner** 15827 Prince Frederick Hughesville Charles Hours Min. 8. Date of Birth NOV. 19 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 20 F 92 Director Yrs. 578-38-2550 MASS Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow must be notified at MD St. MARY'S 1 ☐ Yes 2 No Director Charlotte Hall 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? ŏ U.S.A. "natural", or items 23a 37565 Oaks Rd. Funeral 20622 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2√2 No by Specify: 3 Widowed 4 Divorcad White Completed permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If flem 27 is merked other than "naturary injury or other traumatic avairs". 16a. Dacedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coltaga (1-4or 5+) SECRETARY FEDERAL GOVERNMENT 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Rutherford Charlotte Brehio Rutherford 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Lloyd Brown/Husband 37565 Oaks Rd. Charlotte Hall, MD 20622 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crem. 1/10/98 Alexandria, VA 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility AREHART-ECHOLS FUNERAL HOME, PA MO0945 P.O. Box 567 LaPlata, MD 20646 0 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death bused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical MULTI SYSTEMS FAILURE TO THRIVE Examiner Dua to (or es e consequence of): Examiner physician end s the burief-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in daeth) Lest Due to (or as a consequence of) Physiclan/Medical Due to (or es e consequence of): ettending for use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown à should Completed 24e. Was en autopsy performed? 24b. Wara autopsy findings eveileble prior to completion of cause of deeth? page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No director 25. Was casa raferred to medical exeminar? Be 26. Placa of Death (Chack only ona) Certification: To 1 Yes 28 No Other: 4 Nursing Homa 5 Pesidence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation 1 Yes 2 No 2 Accident d in by the 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Spacify) Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homloide filled in To the Hospital within 24 hours e To the Funeral C completely filled Certifying Physicien: To the bast of my knowledge, daeth occurred et the time, dete end piece, end due to the cause(s) and mennar es stetad.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et tha time, data and place, end due to the ceuse(s) end mannar stated. Medical 29a, Certifiar 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) January 8, 1998 30. Name end eddrass of person who complated cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year) JAN 1 2 1998 32. Ragistrar's Signeture whi attouter Radall 20646

KRISHAN MATHUR, M.D., P.O. BOX 2729, LA PLATA, MD

the Meryland

72 hours efter

that the deeth certificate be executed

Box 68760.

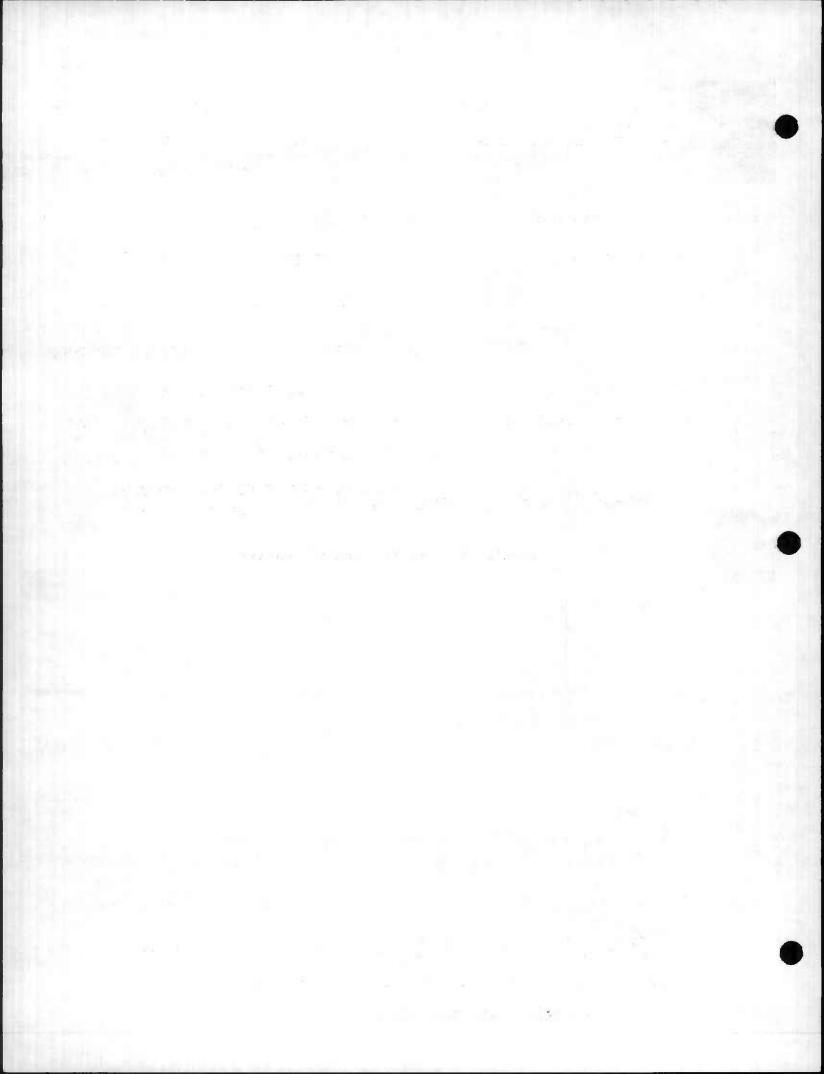
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Division of Vital

Hospital or Attending Physician: 24 hours efter death.

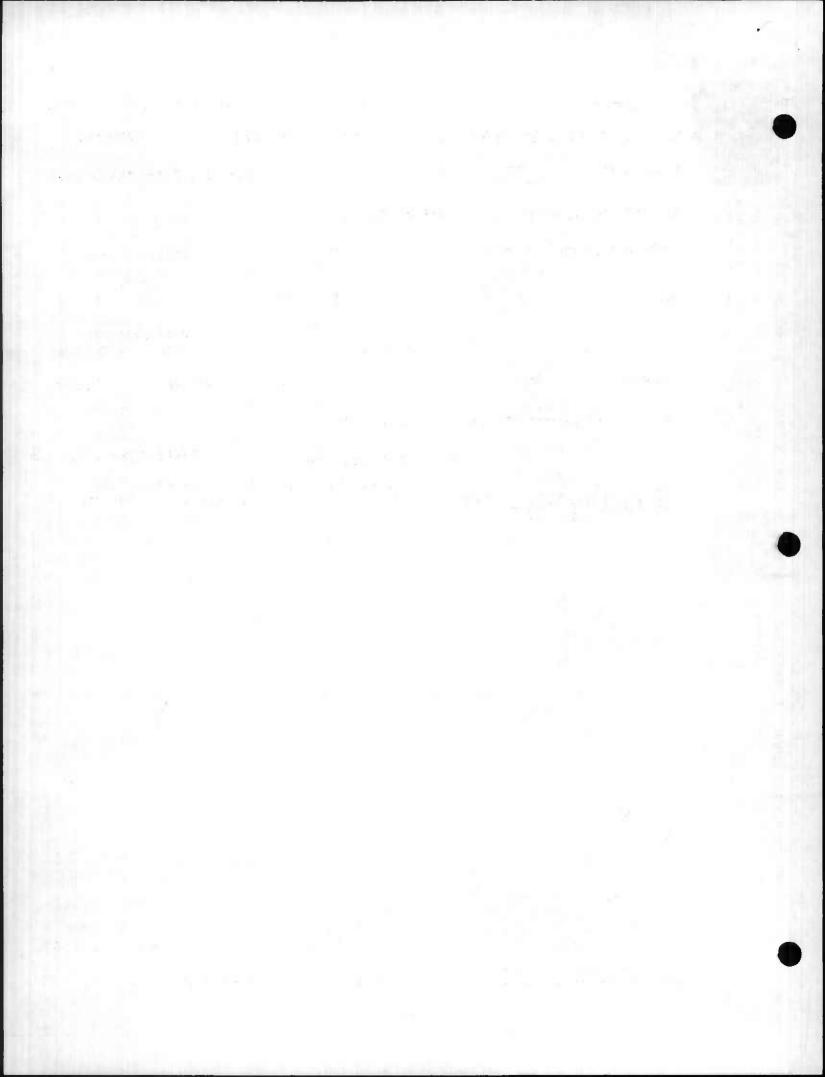
Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Amend #1,1/16/98, BMW, Mantg. Co Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician bn Shills well Roxana V. Burns January 15, 1998 1:15A. /Medical 4a. Facility Neme (If not institution, giva straet end number) 4b. City, Town, or Location of Death 4c. County of Deeth
Montgonery **Examiner** Springbrook Adventist Nursing & Rehabilitation Center Silver Spring If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer, Birthplece (State or Foreign Country) **Funeral** 1□M 200 149-09-8572 Yrs Director 81 July 27, 1916 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at Montgomery Maryland Silver Spring Director 1 ☐ Yes 2XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Briggs Chaney Road 20905 United States Funeral deeth 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Bleck, White, etc. 72 hours after 1 ☐ Yes 2 X X of If Yes, Give Yaar or Dates: 1 Naver Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 XXIO þ Specify: White 3℃Widowed 4 Divorced naturai r than "natural Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry nd 2 should be filed within 72 lith end Mantal Hygiane. 27 is marked other than "na r traumatic event, ine Magn Bell Atlantic Elementary/Secondary (0-12) 12 Coltege (1-4or 5+) Office Clerk Telephone Company 17. Fether's Name (First, Middle, Lest)
George 18. Mother's Name (First, Middle, Maiden Sumeme) Be Taylor Bertha Fraser Vincent Pagas 1 end 2 should nent of Health end Man Lo 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Alexander (friend) Health of Health same as #10 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Paga Department o Important: If any injury or = 6 1/16/98 Oakland Park, Florida 4 ☐ Donetion 5 ☐ Other (Specify) Roberts Funeral Home 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. Bun 4400 Powder Mill Rd. Beltsville, Maryland 20705 Part1. Enter the disease, and shock, or heart failure. Li that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of) Examiner siclan and burial-transit or Attending Physician: The law requires thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): P.O. Box 68760. physician s the buria Physician/Medical thet initieted events resulting in deeth) Last Due to (or es a consequence of): as Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Heimen Wireque 1 Yes 2 No 3 Probably 4 Unknown should be date Records, þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performad? Completed has page 2 2XXN0 1 ☐ Yas XX No cartificate 1 Yes Division of Vital funeral director. Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Deat 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Naturel 5 ☐ Pending 24 hours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 D Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. edicai 29a. Certifier within 2 To the To the 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) January 15, 1998 30. Neme en address of person who completed cause of deeth (Item 23e) (Type, Print) Michael Leibowitz, M.D. 11120 New Hampshire Avenue, #305 Silver Spring, Md. 20904 31. Data filed (Month, Day, Year) State Registrar

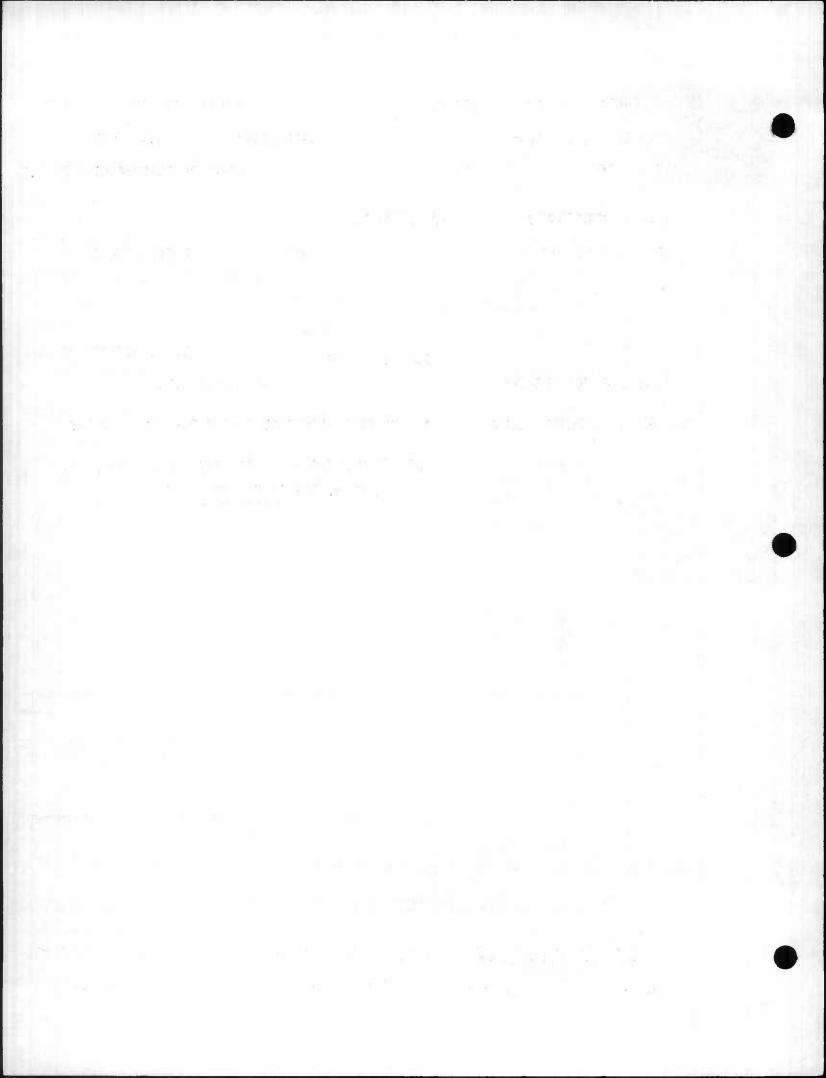


State of Maryland / Department of Health and Mental Hygiene

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	Exami		4e. Fecility Neme (If not institution, give WILSON HEALTH		m <i>ber)</i>				4b. City, To GAITH		SURG		ty of Death		
	Funeral Director			ex □M 22⊀F	7. Age (In yr. 82,	s. last birthday) Yrs.	If Under 1 Months E	Yeer Deys		24 Hrs. Min.	8. Dele of B	25,1915	9. Birth	plece (Sta PNGT)	te or Foreign ON , D . C
	deeth with the Maryland ms 23a or 28a-f show Livest be nottilled at	ctor	Usuel Residence of Decedent 10e. State 10b. County MD. MONT GOME	ERY		City, Town or Li									e City Limits
	23a or 28	ai Dire	10e. Street end Number 301 RUSSELL AVE	ENUE			10f. Zip Co	ode	20877	7		10g. Citizen o			
020	or its	by Funeral Director	11. Meritei Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Dec Armed Fo 1 Tes If Yes, Gi Year or D	edent Ever In orces? 2 No ve etes:		Wes Deceden If Yes, specify 1 ☐ Yes 2.2	Cub	en, Mexican	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		ace - Ameri eck, White, ify: W -		1,
21215-0020	within jiana.	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	lucation de completed) College (dent's Usuei C kind of work of DO NOT use		petion during most d)	t of work	ing	16b. Kind of U. S.			Т
Maryland	should be filed vend Mentel Hygia smarked other thumatic event, In	To Be C	17. Fether's Neme (First, Middle, Last) JOHN CLARENCE BU	JRROWS						ORA		le, Maiden Sume [NNISS	ame)		
	nd 2 sho lith end 27 is me		19e. fnlorment's Name/Reletionship (IRICHARD E. BURROWS	**	ER							ber, City or Tow 10DE ISL			
Baltimore,	Pages 1 er ant of Hee nt: if itam		20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify	Removai from	20b. State	Plece of Disp	osition (Name matory or othe	of or pla	ice)	1	Dete 1/16/98	20c. Location	- City or T	own, Stete	
Balti	permit. Pages 1 end 2 should be filed. Depenment of Heelth end Mentel hypelmportant: if item 27 is marked otherany injury or other traumatic event, once.		21. Signature of Funerel Service Licen		2. 40	2 M	2. Name end A URIEL I	Addre	BARBE	R FL	JNERAL				•
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ital F	an: The le tificata ha tor, paga	Be Cor	25. Wes case referred to medical	how	tte	11/me			26. Place	of Deet	1 Check only	Yes 2010	1	☐ Yes 2	2□ No
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Division	5 P. P. P.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. PIECE	of Injury - At ing, etc. (Spec	home, farm, si	reel, lactory, o	ffice				(Street and Nur own, State)	nber or Rur	al Route A	vum <i>ber</i> ,
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)	ilner: On the b	best of my kr esis of examir ner steted.	nowledge, deet netion end/or In	h occurred et t vestigetion, in	the li	me, dete en opinion, dea	d piace, th occurr	end due to the red et the time	e ceuse(s) end s	menner es : e, end due !	steted. to the ceus	se(s)
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			30. Name ind/eddress of person who d	meu.		om 23a) (Type,	Print) PUSSEC		Mic	6	AITHE	15 134.26	No	e de	79

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 05:00 PM NORA BELL CORN JANUARY FOUND. 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BEACHWOOD PRINCE GEORGES 8006 CLINTON LANE If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. last birthday) 85 Yrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Months Deys 1□M 2XF Feb 4, North Carolina 212 72 3288 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1□ Yas 2 No Forestville PG 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8000 Jordon Park Blvd 20747 United States Wes Decedent Ever in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Datas: 1 Navar Marriad 2 Married 1 ☐ Yes 2 ☐ ▼ o Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife. Home Owner 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1445 Knight Ave, Dunkirk, Maryland 20754 Patricia McDermott 20e. Method of Disposition 1 ☐ Buriel 2 🛣 Cremetion 3 ☐ Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 5 ☐ Other (Specify) 4 Donetion Clinton, Maryland Lee Crematory Jan 9, 1998 21. Signature of Funerel Service Licensee 22. Nama and Address of Facilityee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23a. Pa/11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one celes on aech line. Immediete Ceuse (Final disaase or condition resulting in death) . ARTERIOSCLERGTIC CARDIOVASCULAR DISEASE Due to (or es e conseguança of): Due to (or es e consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) exeminerr 1 X Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

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Certification:

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29a. Certifier

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funeral

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To the Hospital or Attanding Pi within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funera

Box 68760.

P.O.

Division of Vital Records,

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Hasilih and Mentel Hygiane. Important: If time 72 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, its Marilan Examine Institute from the Institute of the Institute Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Wes cese raferred to medical exeminer?

27. Manner of Deeth 5 Pending investigation 1 Natural 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Yeer)

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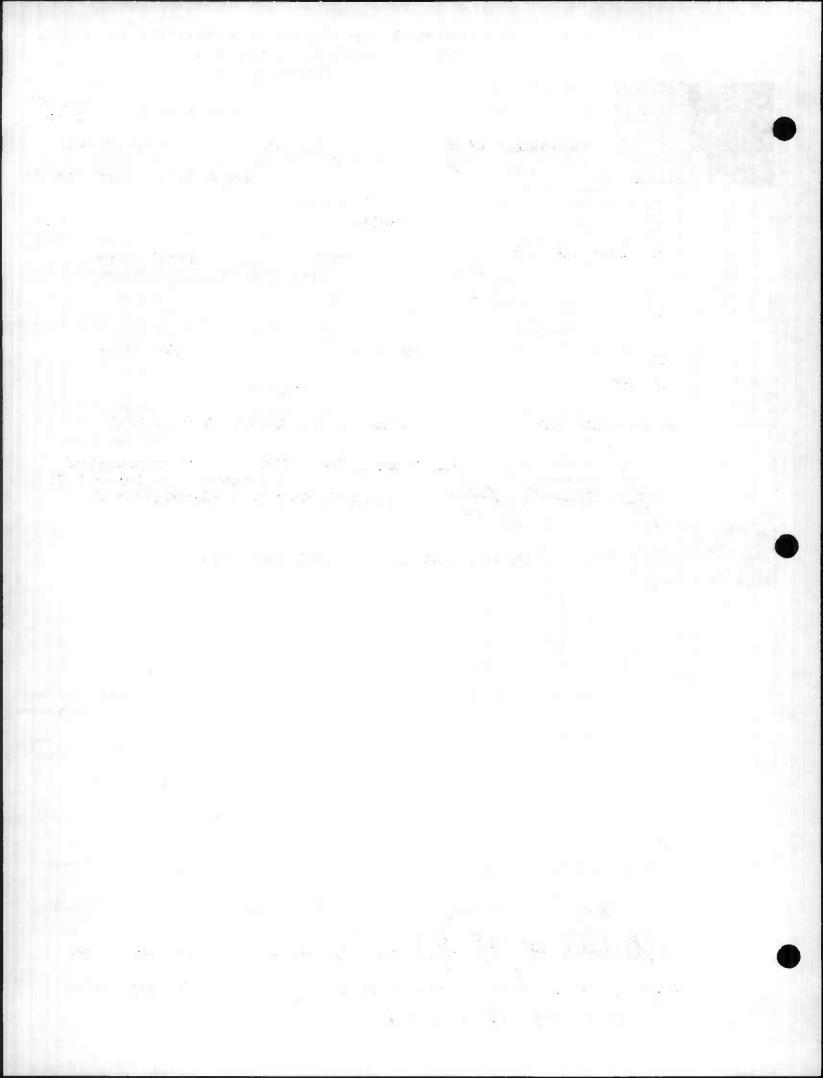
JANUARY 09, 1998

ne of death (hem 23a) (Type, Print) ne and address of person who con 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 GOLLE MD. JR.

MARIO 31. Dete filed (Month, Day, Year) JAN 1 4 1998

32. Registrar's Signeture Achi Stocker Raylett

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month Day **Physician** 9, Myung S. Pang Cho January 1998 2:30 PM /Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** 1₽M 2□ F Months Days Hours Min. Yrs 219-92-2562 90 Director Feb. 16, 1907 Korea Usual Rasidance of Dacedant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Mod Est Examiner must be notfled at 1 ☐ Yes 2 ☐ No Director Montgomery Potomac 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9201 Paddock Lane 20854 United States Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes ② No If Yas, Give Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, etc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Pages 1 end 2 should be filed within 72 hours effer on the fleath end Mental Hygiene.

If it is not 27 is marked other than "natural", or its iny or other traumatic event, the Medical Examine. 1 □ Naver Married 2 □ Married 1 ☐ Yas 🏋 ☐ No Spacify: Bailtimore, Maryland 21215-0020 þ Specify: Oriental 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) housewife home 12 18. Mother's Nama (First, Middla, Maldan Sumama) 17. Father's Nama (First, Middla, Last) Be Hyo Sun Pang Ssee Hong 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Ratationship (Type, Print) Phillip K. Chough /Son 9201 Paddock Lane, Potomac, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burna 2 Cremation 3 Removal from Stata
Dornal on 5 Other (Specify) 1/14/98 Norbeck Memorial Park Olney, MD 21. Signature of Funeral Service Lightise 2. Nama and Addrass of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Ceuse (Finel . Acute Myocardial Infarction diseasa or condition rasulting in daath) 1 week Examiner Dua to (or as a consaquance of): Examiner b. Coronary Artery Disease 1 year Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last -tran Dua to (or as a consequence of): pue the death certificate be execu physician s the buriel burie Box 68760. Dementia year Physician/Medical Due to (or as a consequence of): es . use i 20 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceusa given in Part I. P.0. detached 1 Yes 2 No 3 Probably 4 Unknown á signed b Records. à 24b. Were eutopsy findings availabla prior to complation of ceuse of daath? 24a. Was an autopsy Completed peeu page 2 has 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificete Division of Vital Attanding Physician: funeral director. Be 25. Was cese refarred to medical examinar? 26. Piece of Death (Check only ona) 1 Yas 2 No Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) 2 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury et Work? After 5 Panding invastigation 1 DNatural efter deeth. 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide ò 24 hours e Funeral C 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, deta and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and mannar statad. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 29b. Signatura and titla of certifiar 29d. Data signad (Month, Day, Year) 29c. License number

M. D

Dr. Pankaj Lal 11120 New Hampshire Ave Silver Spring, MD

Davidson-Randelle

32 Registrar's Signatura

1/13/98

State Registrar ancha

JAN 15

31. Data filed (Month, Day, Year)

30. Nama and addrass of parson who completed ceuse of death (Item 23a) (Type, Print)

1998

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Actte Myocardia

Coronary Artery 1

Dementia

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day Month **Physician** Muriel R. Crosby 06:30pm Jan. 12, 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1□ M 2□ F 73 Yrs. Nov. 18, 1924 Kentucky 407-22-1449 Director Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Montgomery Silver Spring 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code death with 2603 Weisman Road 20902 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours eftar 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiens. Important: if item 27 is marked other than any highry or other traumatic avent, the Magnites. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey Preece May Boone 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2603 Weisman Road, Silver Spring, MD 20902 (husband) Earl Crosby 20b. Place of Disposition (Name of camatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 1/15/98 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. West Home, Inc. true Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** ESOTHAGEAL CANCER /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequança of) 80 USB 0 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 has 1□ Yes 2⊠No 1 ☐ Yes 2 ☐ No certificata • Hospital or Attanding Physician: 24 hours efter death. • Funeral Director: After this certific. funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Panding 1 Netural 1 Yas 2 No investigation 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner as stated edical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D10690 ar Ca-Jan. 13, 1998 10 9801 GA AUE SILVER SP. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD EdGIAR VIN

Registrar

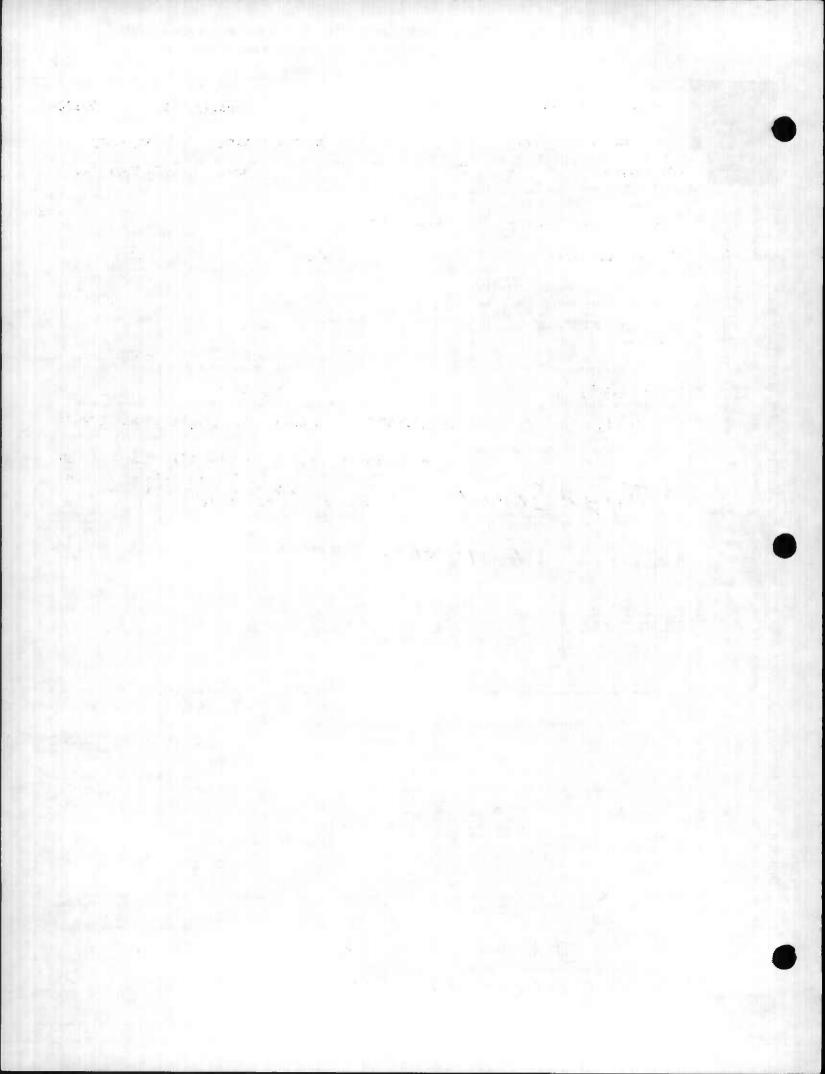
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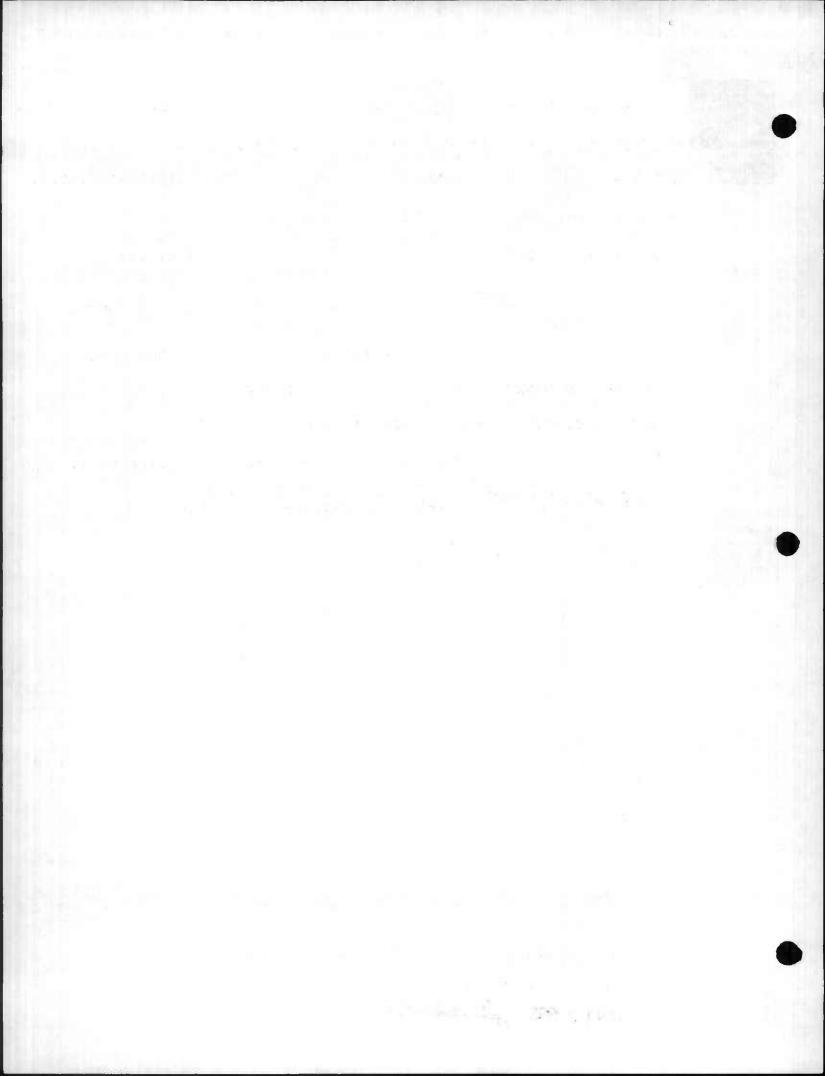
32. Registrar's Signature

hia Davidson



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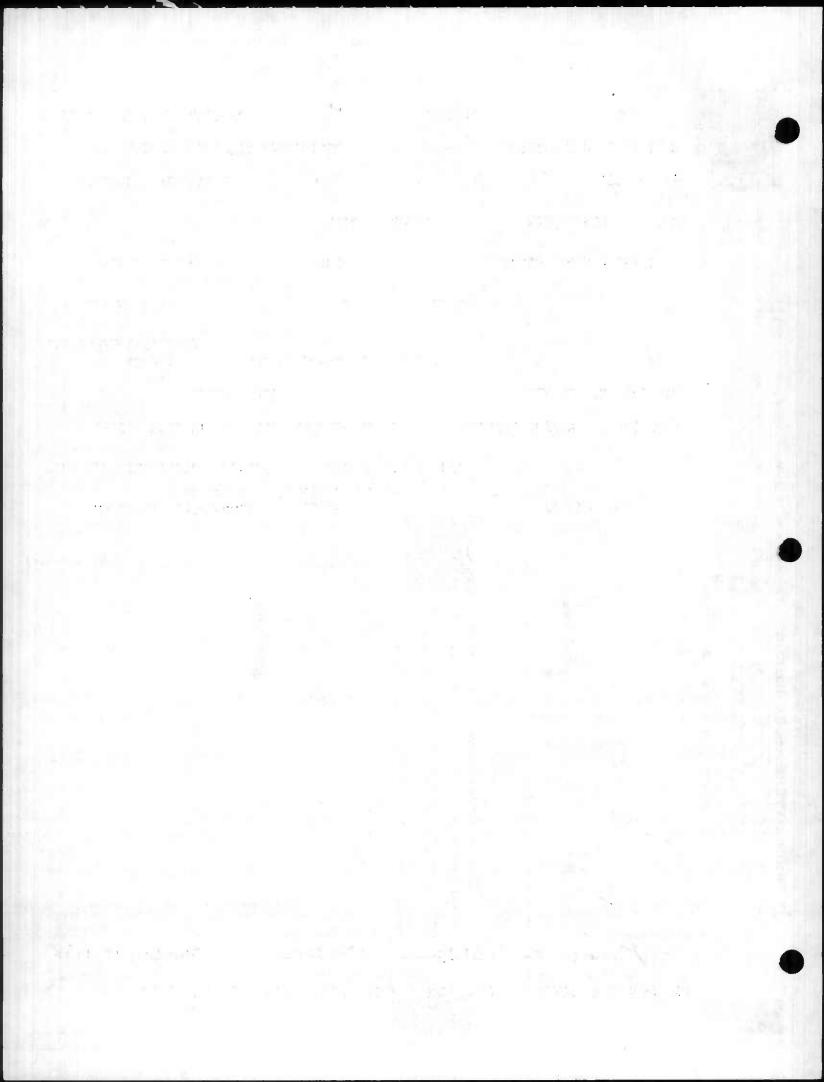
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		Dr. Valerie L. Moore, M			erick, N	1D 206	78			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 84 Certificate of Death Reg. No. 1. Decedant's Nama · (First, Middla, Last) 3. Tima of Death 2. Data of Death Dey Yee Month Melvin B. Clement 12, 1998 5:00 AM January 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Mariner Health - - Kensington Kensington Montgomery | REITS LITE COLL
| If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 1[XM 2□ F Yrs. 076-14-2296 17, 82 Jan. 1915 New York Usual Rasidance of Dacedani 10a Stata 10b. Counts 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 M No Montgomery Silver Spring 10e. Street and Number 10g. Citlzan of What Country? 10f. Zip Code 1812 Florin Street 20902 USA 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Year or Datas: WWII 14. Race - Amarican Indian, Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Bleck, White, etc. 1 ☐ Navar Marriad 2 ☑ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highast grada complated) Elamantary/Sacondary (0-12) College (1-4or 5+) 5+ Musician Entertainment 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Alva Clement Esther Beardsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carmela C. Clement (wife) 1812 Florin Street, Silver Spring, MD 20902 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 DiCramation 3 ☐ Ramovel from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 1/12/98 Alexandria, Virginia 22. Nama and Addrass of Facility Francis J. Collins Funeral 21. Signatura of Funaral Sarvice Licanal 500 University Blvd. West Home, Inc. Cober Man Silver Spring, MD 20901 23a. Part1. Entar tha disaasa, or complications that cause shock, or heart failure. List only one causa on eagle adath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, Approximate Intarval Batween Onsat and Death Immediate Causa (Final disaasa or condition resulting in death) Atherosclerotic Heart Disease vears Dua to (or as a consaguanca of): Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequanca of): Due to (or es e consaquança of): 23b. Did tobecco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 157 Yes 2□ No 3 Probably 4 Unknown Chronic obstructive lung disease, Atrial fibrillation 24b. Wara autopsy findings evellable prior to complation of cause of death? 24a. Was en autopsy performad? 1 Yas 2 No 1 Yes 2 No 26. Placa of Death (Check only ona) Othar: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

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29a, Cartifier

(Check only one)

31. Date filad (Month, Day, Yaar)

permit. Page Department of Important: If any Injury or page.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland nent of Health end Mental Hyglene. Int! If Items 23 a or 28e-f ahow int! If Items 23 a or 28e-f ahow int or other traumatic avent, in a ledges Experies must be notified as iny or other traumatic avent, in a ledges Experies.

Baltimore, Maryland 21215-0020

Brus

physicien and s the buriel-transit the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pl the signed by the director, page 2 s al or Attending Physician: To safter death.

I Director: After this certificated in by the funeral director, pe

Carotid Stenosis, G.I. bleeding, Pneumonia

25. Was case referred to medical examiner? 1 Yas 2 XNo 27. Mannar of Death 5 Panding investigation 1 Watural

2 Accidant 3 ☐ Suicide 6 Could not be 4 Homicide

1 Yas 2 No 28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and dua to the causa(s) and manner stated.

29b. Signatura and titla of cartifiar

29c. Licansa number

28c. Injury at Work?

29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata)

D08944

January 12, 1998

30. Name and addrass of person who complated auda of death (Item 23a) (Type, Print)

Martin Shargel, M.D. 3720 Farragut Avenue, Kensington, MD 20895-2110

State Registrar

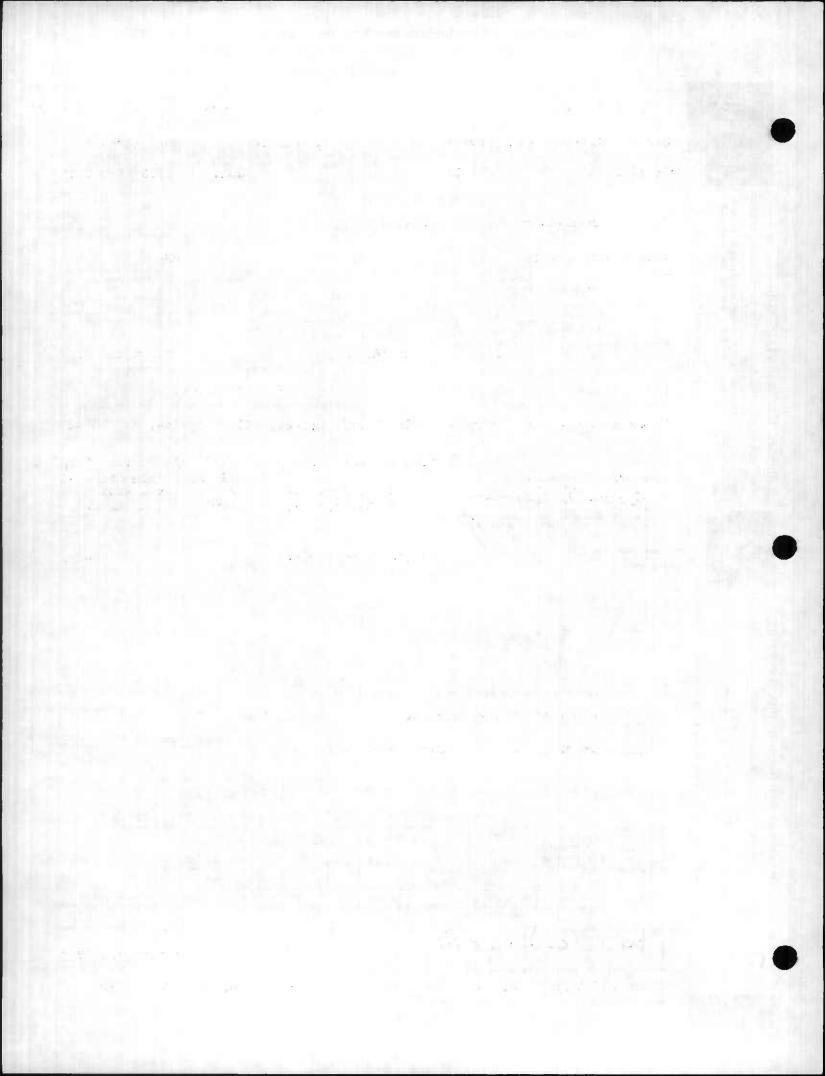
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DHMH 16 Rev 6/95

24 hours aft Euneral Di letely filled in

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month January 10, 1998 8:55 PM Carolyn Frances Cooke 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) 10M NOF 479-26-0180 Yrs 71 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13015 Broadmore Road 20904 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Nurse Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Helen Stahl Herbert James Cooke 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Cooke Anastasi (niece) 118 South Adams Street, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-14-98 St. Marys Cemetery Rockville, Maryland 22. Name end Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 21. Signature of Funerel Service Licensee 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth year

Physician /Medical Examiner

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Bud

physician s the burie

Sign

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice

24 hours

To the Hospl within 24 hou To the Funer completely fil

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Director

Funeral

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10e State

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the Maryland

Pages 1 end 2 should be filed within 72 hours efter death with the Marylan nent of Heatth end Mentel Hygiene. Int: If Item 27 is merked other than "naturel", or items 23a or 28a-1 show ary or other traumetic event, the Medical Examiner must be not ted.

Baltimore, Maryland 21215-0020

Examine Physician/Medical þ Be

Immediate Ceuse (Finel diseese or condition resulting in death) Pulmonary Disease Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 1 □ Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 20 No 1 inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier

15 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. (Check only one) 29c. License number

29b. Signeture end title of certifier Kenniskaf Mis.

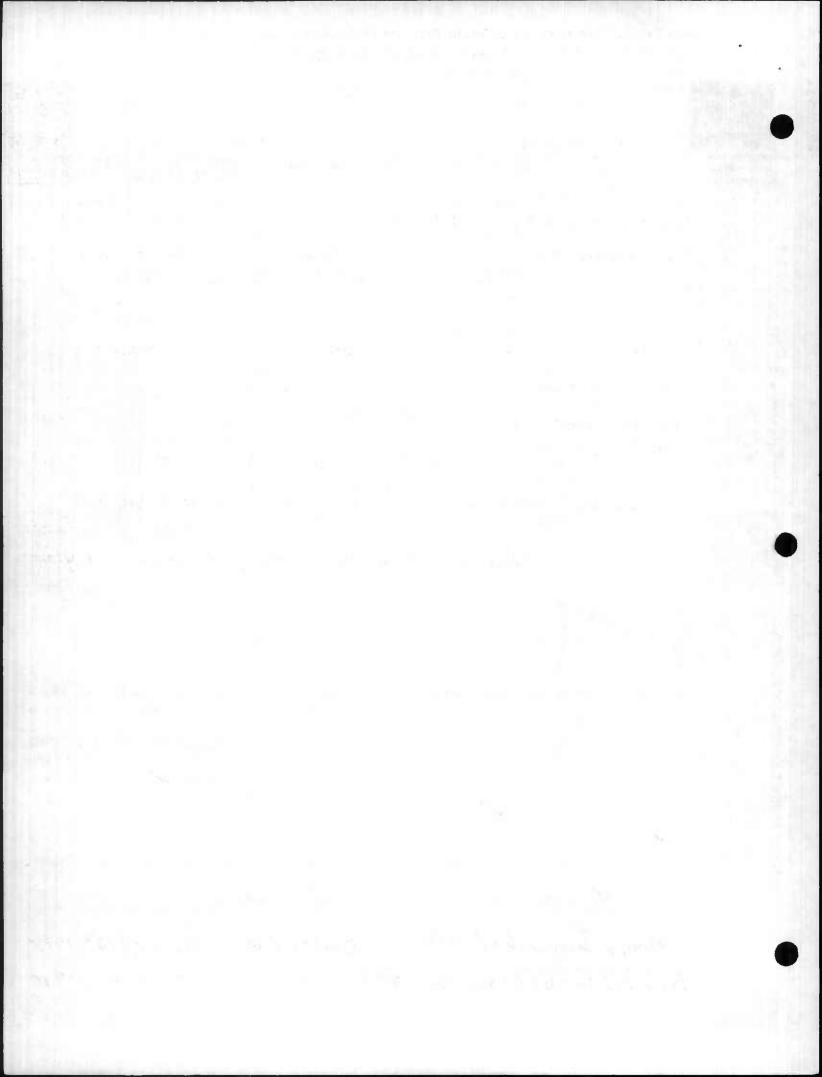
D-20062

29d. Date signed (Month, Dey, Yeer)
Tanwary 12th, 1998

30. Name end eddress; of person who completed cause of death (Item 23e) (Type, Point).

TONY P. KANNARICA T.MD. 820/ 1685. SILVER SPRINGI MARYLAND

State Registrar 32. Registrer's Signeture Julia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month **Physician** Nellie Martha Creamer January 12, 1998 10:30AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner 6416 83rd Place Cabin John Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Deys 1 □ M 2 🕅 F Yrs. Director 87 577-01-4054 July 28, 1910 Washington, DC Usuel Residence of Decedent tha Maryland 10a State 10h. County 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 ☐ Yes 2√No Director Maryland Montgomery Cabin John 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6416 83rd Place 20818 United States daath Пета 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. marked other then "netural", or Item imatic event, the Medical Examiner filed within 72 hours aftar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Hygiena. College (1-4or 5+) 8 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Pagas 1 and 2 should be file mant of Heelth end Mental Hy lant: If Itam 27 Is marked oth jury or other traumatic evam Be Grace Ethel Cumberland John Bernard Marshall 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Miller/Niece 6416 83rd Place, Cabin John, Maryland 20818 20b. Place of Disposition (Name of cametery, cremetory or other place)

January 14, 199

Montgomery Crematorium, Inc. 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Department of important: If any Injury or once. 1998 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ اف. Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Betehsda, Maryland 20814-3501 23a. Pert1. Enter the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel disease or condition resulting in death) Congestive Heart Failure **Examiner** Due to (or es e consequenca of) Examiner Coronary Heart Disease The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. physician Physician/Medicai Due to (or es e consequenca of): USB BS eta has bean signed by tha a page 2 should be dateched t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records, by Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? certificeta has 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residenca 6 ☐ Other (Specify) 2 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funaral 28e. Dete of Injury (Month, Dey Year) 27. Mariner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? Aftar 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident after daatt the 6 Could not be determined To the Hospital or Atterview within 24 hours after dar To the Funeral Directo complatally filled in by the 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier (Check only one) 1 🔀 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner as steted. Medicai 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Division of Vital

Brud

State Registrar Brent A. Berger, M.D. 11125 Rockville Pike, #103, Rockville, Maryland 32 Registrar's Signeture Julia Davidson Randell

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

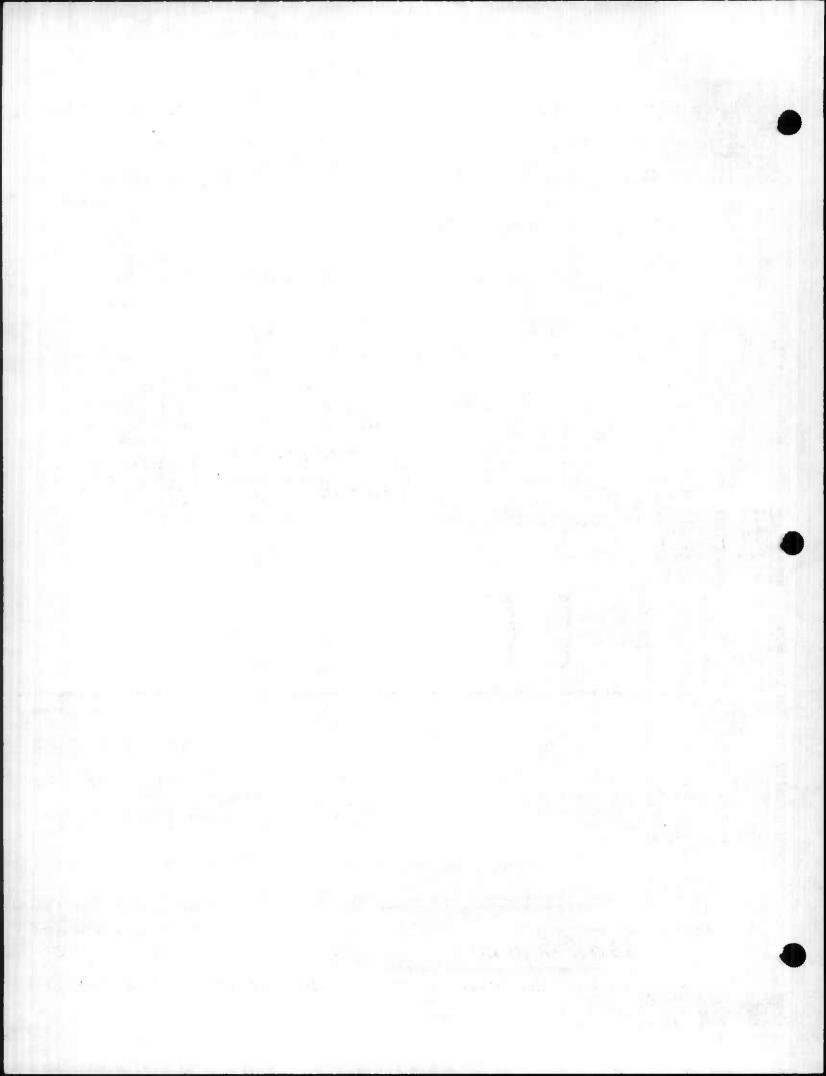
31. Dete filed (Month, Dey, Year)

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13, 1998

January



State of Maryland / Department of Health and Mental Hygiene Cer

Tunient or i	lealth and Mental	Trygierie (
tificate of	Death	Reg. No.	

Physician /Medical **Examiner**

Director

Funeral

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Physician/Medical

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Certification:

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State

Registrar

3 Suicide

29a. Certifier

4 Homicide

MONTGOMERY Birthplece (State or Foreign Country)

10d. Inside City Limits

20868

Approximete Intervel Between Onset end Deeth

1 Ves 217 No

3. Time of Deeth

1056 P

Funeral Director

with the Mandend ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at

death Hygiene.

IL Pages 1 and 2 should be seen and Mental in them 27 is marked of

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

and the buriel-trar certificate be exec physician 98 ettending USB lor the detach á signed be del peeu has pege 2 certificate Hospital or Attending Physician: 24 hours after death. Funeral Diractor: After this certific director. funerel In by 24 hours

P.O. Box 68760

Division of Vital Records.

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev Yeer Lois F. Crider JANUARY 08,1998 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver Spring 4201 HAVARD ST. 8. Date of Birth (Month, Dey, Year) Dec. 20, 1925 If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Months 1□M 2☑F 72 Yrs 440-24-2262 Oklahoma Usuel Residence of Decedent 10b. County 10c. City, Town or Location Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Havard Street 20906 USA Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indien, 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck. White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2☑ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Yeer or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Health Services/ Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Federal Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruby Harrington Fred Decker 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rod L. Crider Sr. (son) 1224 Spencerville Road, Spencerville, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1/14/98 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia Francis J. Collins Funeral 21. Signature of Fuperal Service Licensee 22. Name and Address of Fecility 500 University Blvd. West Home, Inc. a obser 20901 Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Immediate Cause (Finel) . Attenopleratic cardiovascular disease disease or condition resulting in deeth) Due to (or es e consequence ot): Due to (or es e consequence of): Due to (or es e consequença ot)

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

24b. Were eutopsy findings evailable prior to completion of cause of deeth? 1 Nes 2 No

1 Sives 2 No

25. Wes case reterred to medical 26. Plece of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1X Yes 2 No

28b. Time of

27. Manner of Deeth 28e. Date ot Injury (Month, Dey Year) 5 Pending investigation 1 Naturet 2 Accident

6 Could not be determined 28e. Pleca of Injury - At home, term, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner stated.

29b. Signeture end title ot cartifier lonald & Wright MD 29c. License number OCME

28c. tnjury et Work?

29d. Date signed (Month, Dev. Year)

JANUARY 11,1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT MO 111 Penn Street, Baltimore, Maryland 21201

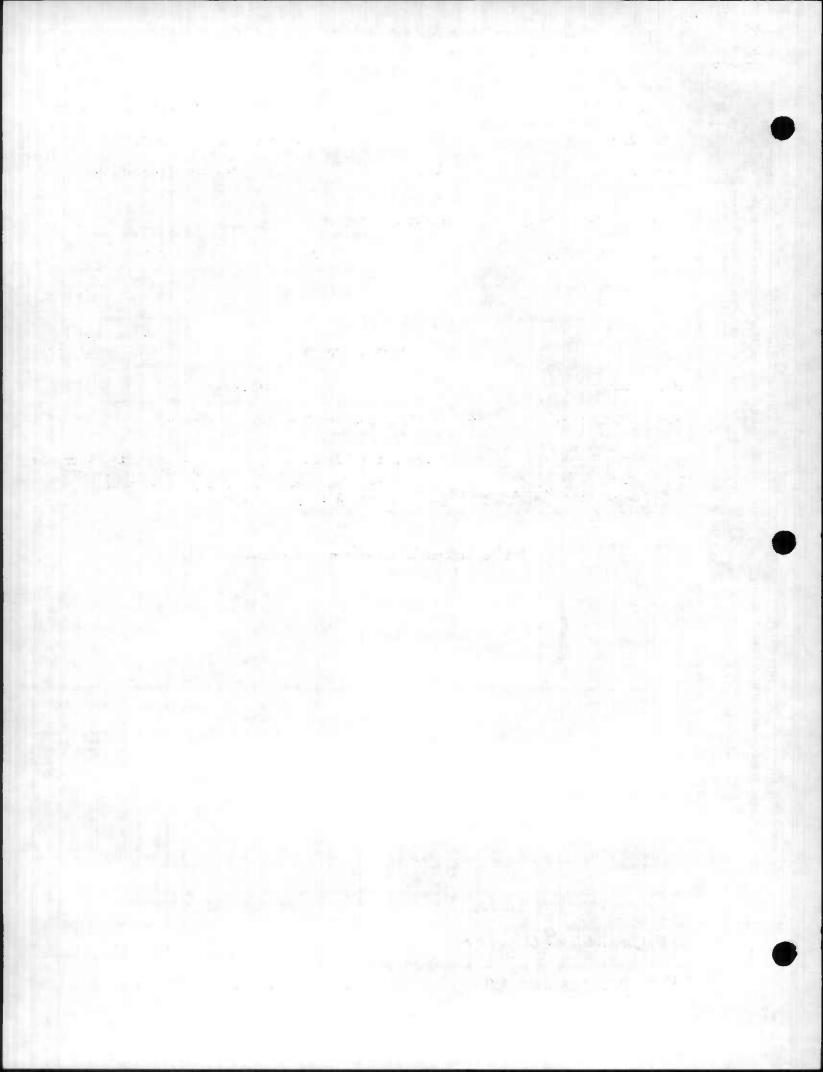
31. Date tited (Month, Day, Year)

32. Registrer's Signeture

Iulia Davidson JAN 14

To the within 2

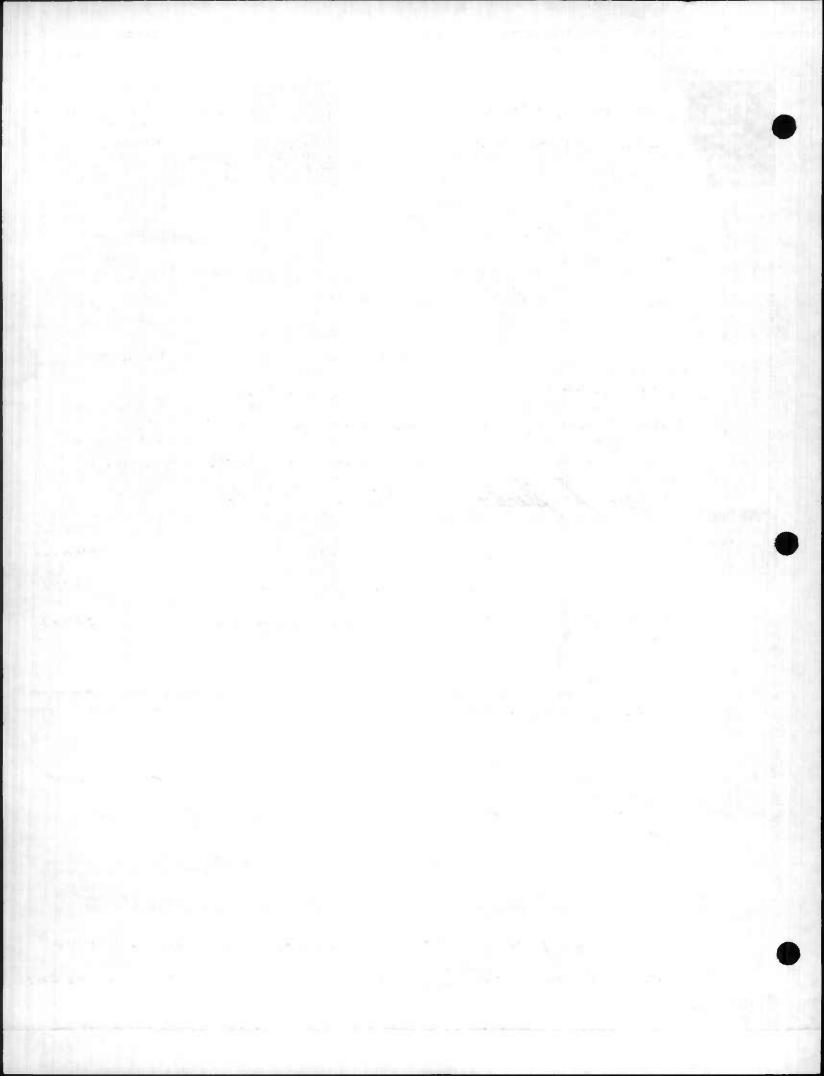
8



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Day James Anthony DeFalco January 7, 1998 4:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 228-42-2955 63 Jan. 2, 1935 Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3605 Bermuda Court 20832 USA death 12. Was Dacedent Ever in U,S. Armed Forces? 1 ∰ Yas 2 □ No If Yes, Give Year or Dates: 1952-55 Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: g Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiane. Elementary/Secondary (0-12) Collage (1-4or 5+) 12 Electrician Electrical other 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Pages 1 end 2 should be fill mant of Health and Mental H ant: If Item 27 is marked oth Anthony C. DeFalco Joan Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) Michael J. DeFalco 20832 (son) 3605 Bermuda Court, Olney, MD other 20b. Place of Disposition (Name of cematary, crametory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, State ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 1/9/98 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Sarvica Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final GRAM NEGATZUE SEPSIS 24 HOURS diseasa or condition rasulting in death) Examiner Due to (or as a consequence of): 30145 Left Lower Lobe nnes mosio physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): ESHERICIA INfectiON 30445 certificate be Physician/Medical Dua to (or as a consequence of): attanding p P.O. signed by the at d be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARCZNOMA Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yas 2 No 1 Yes 2 No Division of Vital Be 25. Was case raferred to medical 26. Place of Death (Chack only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatlent 3 DOA funerel 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Cortifying Physician: To the best of my knowledga, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

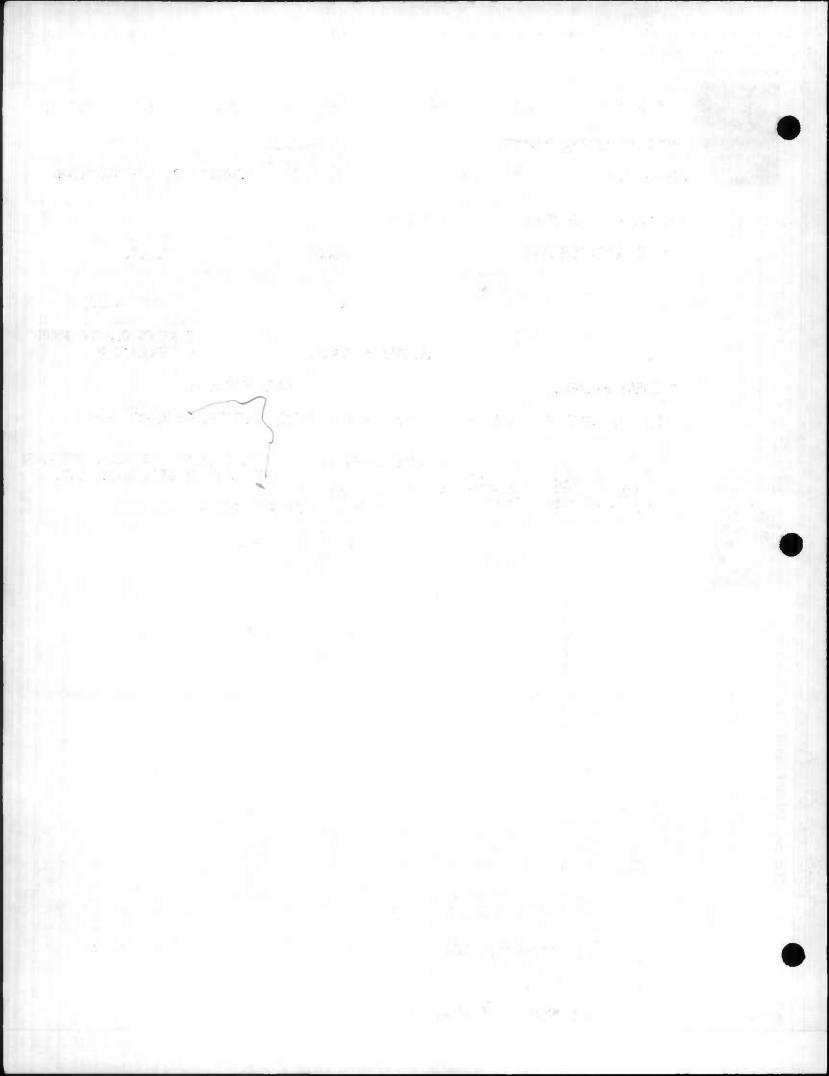
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 27 y. my. wo 023630 JONUOTY 8, 1998 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) 16220 Frederick Roid # 213, baithers burg Mo 20879 Frank J. MAYO, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Vilia Savidson-Randelle JAN 12 1998 Registrar

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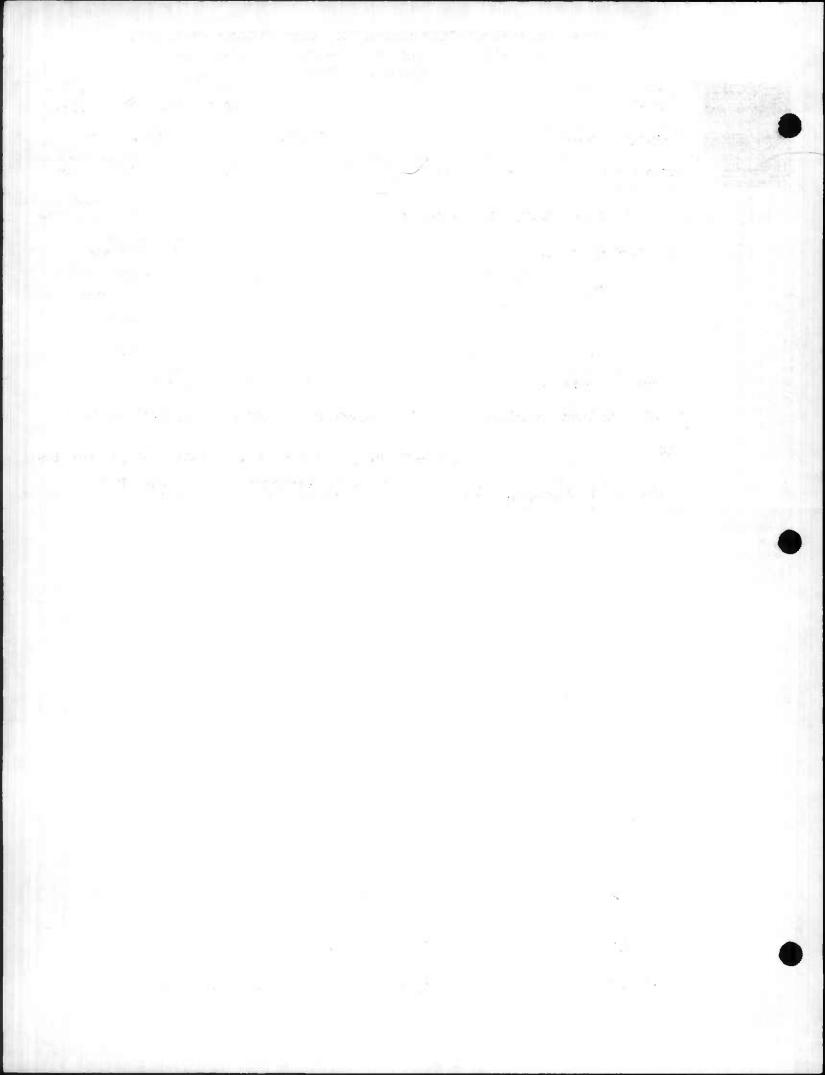
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

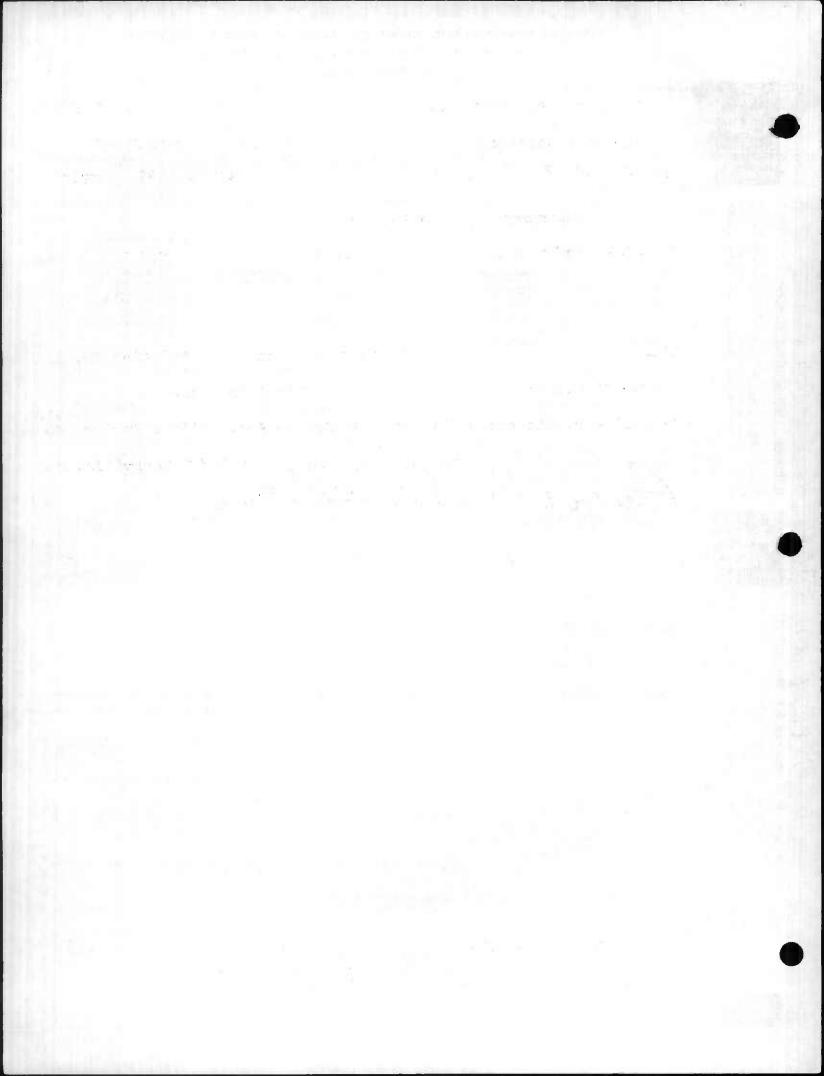
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and Mental is marked o	To Be	Giacomo Sparagn					Angelin		llozzi		
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Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, once.		20e. Method of Disposition XXBuriel 2 Cremation 3 4 Donetion 5 Other (Specify)	Removal from Stete	cemeter	Disposition (Ner y, crematory or o	ther ple	n Cemetery	Dete 1/13/1		City or Town, S	
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and transit	edical Examiner	Sequentially list conditions,					70				
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tha attanding physician and thed for usa es the bunal-transit		resulting in deeth) Lest	Due	e fo (or es e c	onsequenca of):	1					
a attar	Physician/M	Pert ii. Other significant conditions cor	ntributing to death but n	ot resulting In	the underlying of	ause di	iven in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of dea
been signed by tha attandin should be deteched for usa	by Phys				, ,				Yes 2□ No	3 Probably	1/
80 CI	Completed							24e. Wes perfo	en eutopsy med?	evellebl	utopsy finding e prior fo tion of cause 1?
cata h	Con							101	res 2 No	1 □ Yes	2 No
s certificata hes b director, page 2 s	o Be	25. Wes case referred to medical exeminer?	lospital:	- C rn/o		Ot	26. Plece of Deet				
67 0	ation: To	27. Menner of Death 1 Netural 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Day Year) Property Property 28b. Time of Injury 28b				A Other: 4 Nursing Home 5 Residence 6 Other (Spe Sc. Injury et Work? 1 Yes 2 No				
within 24 hours effer death. To the Funeral Director: Affer this completaly filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury building, etc. (5	- At home, far Specify)	rm, street, factor	y, office		28f. Location (S City or Tox	Street end Numb vn, Stete)	per or Rurel Rou	ite Number,
Euner Funer staly fill	edical	29e. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of m	aminetion end	deeth occurred	et the ti	ime, dete end plece, opinion, deeth occurr	end due to the red et the time,	cause(s) end me date end placa,	enner as steted end due to the	cause(s)
vithin Fo the comple	Mec	29b. Signeture emd title of certifier	end menner stated	1.	29	c. Licen:	se number	Т	29d. Date signe	d (Month, Dey,	Year)
within 24 hours effe To the Funeral Dira completaly filled in a		1 dans				D	52457		1/	11/98.	
1						0	3 - 1 - 1		. /		
6		30. Name and address of person who co		h (Item 23e) (Type, Print)		3 - 7 3 7			. (/0	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

								C	erunc	ale oi	Deam		Reg. No.			
	Physic	nian	1. Decedent's Nan	ne (First, Middl	le, Last)							2. Dete of D		Year	3. Time	of Death
	Physic /Med		ST	ANLEY	E.	. DI	CKERS	ON				JAN.	9, 1	998	12:1	0 P.
	Exam		4e. Fecility Name	(If not institution	n, give stre	et and nun	nber)				4b. City, Town, or L	ocation of Dee	th 4c. County	of Deetl	n	
	4		Su	burbar	n Hos	spita	1				Bethes	da	MONT	GOM	ERY	
134	Funera		5. Social Security		6. Sex		7. Age (In yrs	. lest birthde		der 1 Year	If Under 24 Hrs.		irth ley, Year)	_	hplace (State	e or Foreign
100	Directo		214-36	-2866	1) Ø M	2□ F	58	Yrs.	Monti	hs Days	Hours Min.	Mar.	12,1939) N	untry) laryla	bas
	D		Usuel Residence	of Decedent												4114
	how		10e. State	10b. County				ity, Town or							10d. Inside	City Limits
	Ma Fe	Ş	MD	Mon	tgome	ery		Gaith	nersl	burg					1 □ Ye	s 2X No
	Ith the Marylan or 28a-f show	i e	10e. Street end Nu						10f.	Zip Code			10g. Citizen of	Whet Co	untry?	-
	th wit	0 10	23 Sch	nool D	rive	Rd.				208	878		U.S	5.A.		
	C Z I Z I S-UUZU (Iled within 72 hours after death with the Maryland Hygiane. ther then "natural", or frems 23s or 28s-f show ont, tre Medical Examiner must be notified a	Funeral Director	11. Marital Status		12.	Was Dece	dent Ever in U	J,S. 1	3. Was De	cedent of I	Hispanic Origin? (Speen, Mexican, Puerto	pecify Yes or N	o- 14. Ra	ce - Amer	rican Indian,	
	or he	Ē	1 ☐ Never Mar	ried 2 Mari	ried	Armed For 1 XYes	2 □ No					o Rican, etc.)		ck, White		
2	A I A 15-0020 d within 72 hours aft giane. r then "naturei", or	by	3 Widowed	4 Divorced		tf Yes, Give Yeer or De	tes: 61-	63	1 ∐ Yes	s 2X No	Specify:		Specif	y: B1	ack	
	72 hours "natural",	Be Completed	10	15. Deceden	it's Education	on		16a. De	cedent's U	Isuel Occup	pation		16b. Kind of B	usiness/l	Industry	
1	Min 7	Die.		ondery (0-12)	T	College (1-	40r 54)	life	DO NO	Work done T use retire	pation during most of world ed)	king				
0	C Z I Z filed withi Hygiane. wher then	E	Elementary/Sec	Oridory (0-12)		College (1	401 317	P	rint	ter I	Pressman	1	Print	ina	Co.	
00	be filed other event,	e	17. Fether's Name	(First, Middle,	Last)						18. Mother's Nam	ne (First, Middi				
a :	vid be Wantal rked o	To	George	Dicke	ersor	1					Virgi	nia H	ackney			
1	sh of a		19a. Informent's N	leme/Relations	ship (Type,	Print)		19b. Me	eiling Addr	ess (Street	t and Number or Ru	rai Route Num	ber, City or Town	Stete, Z	ip Code)_	
-	CENL		Kather	ine R	. Die	kers	son (s	Siste								910
	D - 7 5 5		20a. Method of Dis				20b.	Piece of Dis	position (rveme or	Swego A	Date	20c. Location	- City or	Ing, Town, State	MD
	Demit. Pages Depertment of P Important: If ite any injury or of			☐ Cremetion 5 ☐ Other (S		ovel from S	tate	cemetery, c				. /2 4	(0.0			
	rtan njur		21. Signature of F		-	1	1 1-3	rucol			Cemetery	1/14/	198 Roc	kvi	lle,	MD
5	permit. Depentrimporta			na	V	11	100 11	bla			FUNERAL	HOME	РΔ			
of my			Ca	11/4	L	101	www.	aceu	ROCK	CALLI	E, MD	20850				
-0			23a. Pert1. Enter shock, or her	the disease, or ort lailury. List	complication only one or	thet ca	used the dee ech line.	th. Do not o	enter the n	node of dyi	ing, such es cardiec	or respiretory	errest,		Approxim intervel B	etween
3	Physician	_		U)		į	Onset en	d Deeth
0	/Medical	_	fmmediete Ceuse disease or condition	on		Lu	ins	Can	nce	5					7m	200
10	LAMINITE		resulting In death)			-		or es e cons	sequence	of):						
N)	D #	Examiner			- h									i		
	acute ind	Eam	Sequentielly list of	onditions,	7		Due to (or es e cons	sequence	of):						
25	dan a	Ē	Sequentielly list or if eny, leeding to in cause. Enter Und Ceuse (Disease of thet initieted event	ertying										1		
0	certificate be executed rding physician and use es the buniel-transit	n/Medicai	thet initieted event resulting in deeth)	s Last	·		Due to (or es e cons	equence o	of):				+		
	ing p	N N			2.0									1		
W.		and			d											
Q' a	thet the death ed by the atter detached for	Physician	Pert II. Other signi	ficant condition	ons contribu	uting to dea	ath but not re:	sulting in the	underlyin	ng cause gir	ven in Pert I.	23b. Die	i tobecco use co	ntribute	to the caus	e of death?
10	by the	ř.										1.0	Yes 2 No	3 □ Pr	obably 4	Unknown
7	s the	by			_											
. 0	The Corrus, F.O. Do The law requires thet the death ate has been signed by the atte page 2 should be detached for	8											s en eutopsy	24b. V	Vere eutops	y findings
7	aw re	Completed										per	formed?	0	completion of deeth?	
P	The lav	E										15	Yes 2 No			SS No.
3	Vician: The		25. Was case refe	rred to medica	1						00 51 (5		7.50		I □ Yes 2	E NO
**	Sicla cart irect	Be G	examiner?		Hosp	oital:				- Ott	26. Plece of Dee					
*	ald this	. To	27. Menner of Dear		2			ER/Outpat 28b. Time		DUA	4 Li Nursing H		how injury occur		ify)	
	After fune	te	1 Naturel	5 Pendin		(Month	f Injury o, Day Year)	Injun		28c. Inju Wo	rk? Yes 2 □ No	Edd. Describe	now anjuly occur	100		
	daat daat tor:	Certification:	2 ☐ Accident 3 ☐ Suicide	8 Could	not be	19a Diago	of Injury - At h	ama farm			1 163 2 110	204 Location	(Street end Numi	har ar Du	und Davide Af	
3	or A political distriction of the politic distriction of the political dis	Ī	4 Homicide	determ	nined 2		g, etc. (Speci		street, rec	tory, onice			own, Stete)	Jer or Mu	rai moute ivu	imber,
	pital ours ours filled	Ö	20a Cadillar	4000 0 - 416-1-	- Dharlet	T- d - b										
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director. After this cartifice completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	2 Medical	Examiner:	On the bas	sis of examina	owiedge, de ation end/or	ath occurr investiget	ed et the ti	me, date end place, opinion, deeth occur	, end due to the rred et the time	ceuse(s) end m , dete end place,	end due	steted. to the ceuse	e(s)
	thin the	Med	29b. Signeture end	title of cortific		end menn	er Steted.			20n Linner	eo number		20d Date start	od /4.4cm/l	Day Mar	1
	5.≱ € 8		250. Signeture end	Title of Certifie	(200	20			29c. Licens	11 11		29d. Date signe			
	9		1	-ce	200						3443		Januar	4 9,	, 1998	
	U		30. Neme end edd	ress of person		eted cause	of deeth (Ite	m 23e) (Typ	e, Print)	Allan	1 POllAC	K, MD				
			809 Vil				1600	cu, 1/e	, N	10	20851					
	St	ate	31. Dete filed (Md	Allay, Top)	1998	32/19	distrate 300	ature 70	delle							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 1998 **Physician** Kha Thi Do January 11, 2:30 PM /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 400 Southampton Drive Silver Spring Montgonery It Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey Year)

Monthe Deys Hours Min. December 31, 5. Sociei Security Number 9. Birthplace (State or Foreign Country) V1et Nam 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 KF 220-21-8086 32 1915 Yrs Director Usuei Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location r 28a-f show 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Exercises must be 400 Southampton Drive 20903 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritai Stetus 14. Race - American Indian, Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced Vietnamese Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) own home none homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Trang Van Do Ruc Thi Tran 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hoc Van Tran (son) 400 Southampton Drive, Silver Spring, MD Item 27 other t 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete = 5 Department in important: If any Injury or once. 1-12-98 Chesapeake Crematory Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Betweer Onset end Deetl **Physician** Immediete Cause (Finei disease or condition resulting in deeth) /Medical ASTHMA Due to (or es e consequence of): BRON CHOS PASM Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es a consequence of) Physician/Medical Due to (or es e consequence of): SB USB for signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NONE þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed certificata hes 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 26b. Time of injury 28c. Injury et Work? 26d. Describe how injury occurred Certification: 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident And Andrews In Section 24 hours of the Funeral Director of the Andrews of the And 3 Suicide 6 Could not be 26f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as steted. Medical

Division of Vitai Records, or Attend after death Director: Hospital To the I within 2 To the I complet

death.

eleased by Dr. Francis C. Mayle, Deputy

with the Manyland

72 hours after death

2 should be filed within and Mental Hygiena.

Pagas 1

Maryland 21215-0020

Baltimore,

Montgomery County

for

State Registrar

31. Dete tiled (Month, Day, Year)

29b. Signe are end title of certifier

(Check only one)

29c. License number

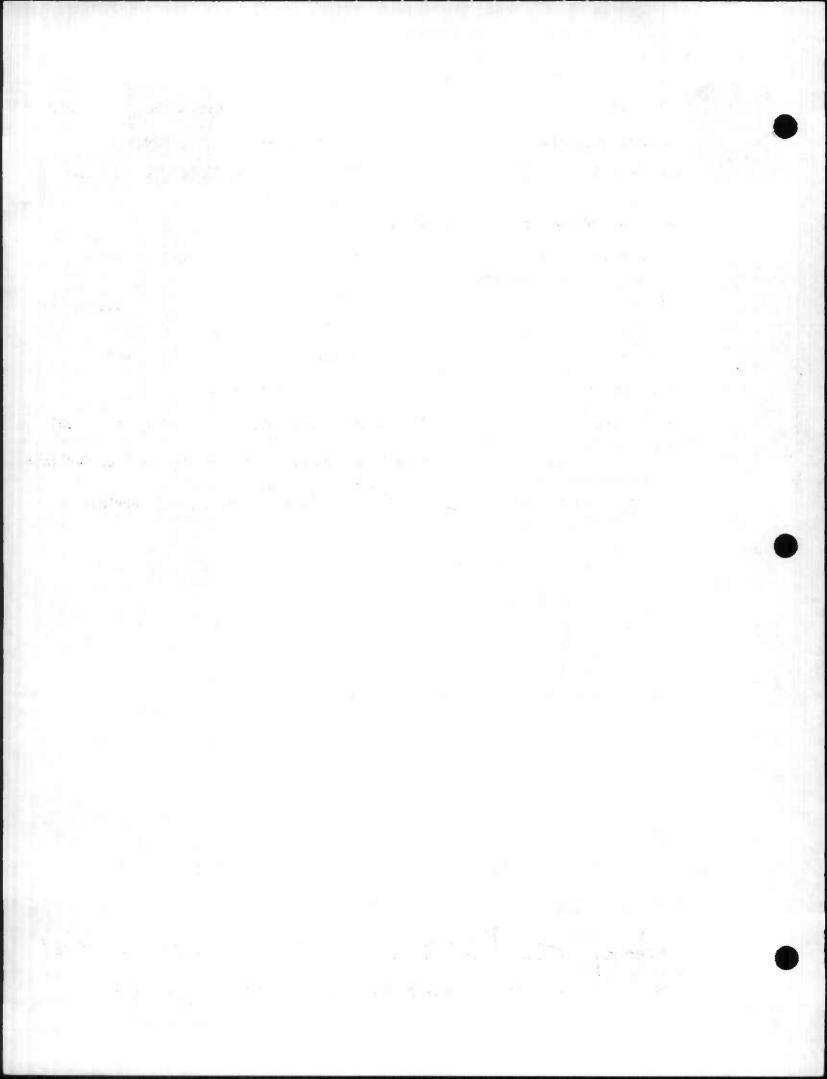
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year) JAN 12, 1997

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

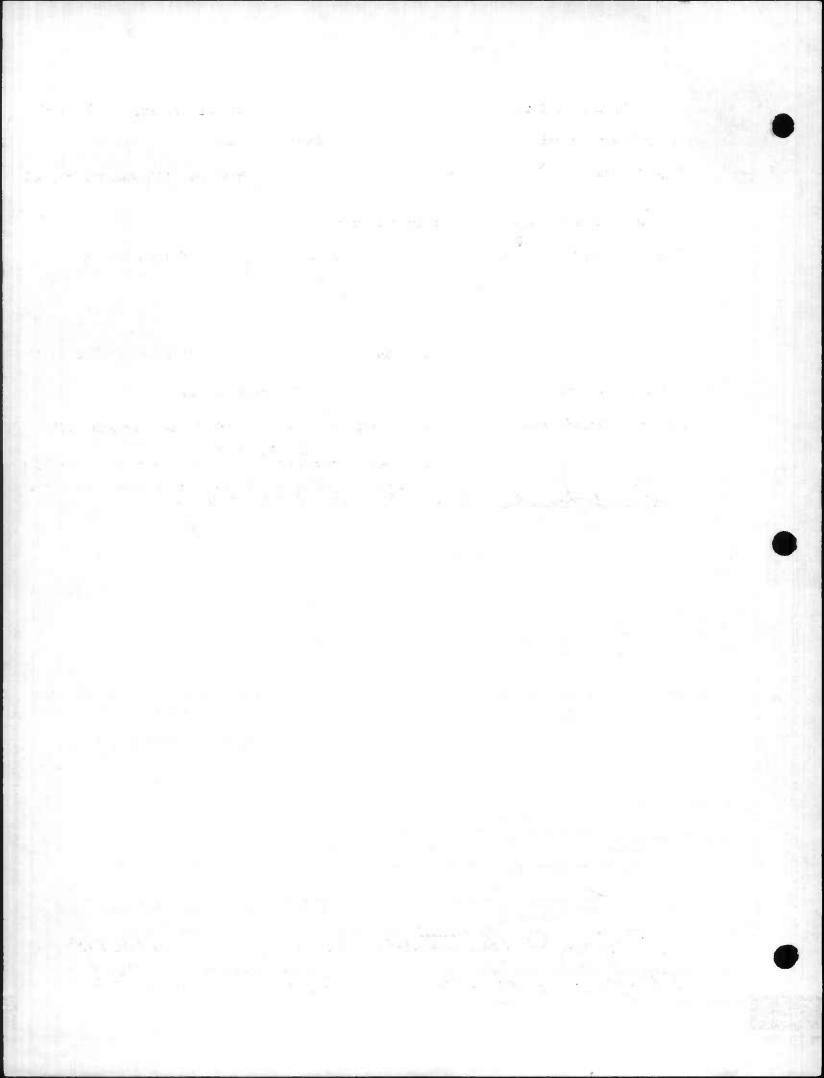
Dang C. Bui, M.D. 400 University Blvd. East, Silver Spring, MD

32. Registrer's Signature JAN 12 1998 Julia Savidson Randoll



State of Maryland / Department of Health and Mental Hygiene 9 8

		1. Decedant'a Name (First, Middla,	Last)		00,	tificate of	Doutil	2. Date of Deet		3. Tima ot Daath		
Physici.		Robert E.	Dore					Month January	7, 199	Year 8 7:38 PM		
Medio/ Examin		4a. Fecility Name (If not institution,		ber)		7	4b. City, Town, or L	-	4c. County of			
		Holy Cross Hosp	ital				Silver Sp	ring	Montg	gomery		
uneral irector		5. Social Sacurity Number 212-64-6344 Usual Rasidance of Dacedent	S. Sax 7. 12 M 2 □ F	. Aga (In yrs.	(lest birthday) Yrs.	Months Deys		8. Date of Birth (Month, Day, April 24	Year) , 1953 V	9. Birthpleca (Stata or Foreigr Country) Vashington, DC		
MO #		10a. Stata 10b. County		10c. C	ity, Town or Loc	cation				10d. Inside City Limits		
Hed.	tor	Maryland Montg	omery		Silver	Spring				1 ☐ Yes 2 ☒ No		
or 28	Directo	10e. Street and Numbar				10f. Zip Coda		10	g. Citizen ot W	. Citizen ot What Country?		
23a	rai	8555 Geren Road				20	901		United States			
"natural", or items 23a or 28a-f show	by Funeral	11. Marital Status 1 ☑ Navar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	Armed Forc	es 2⊠No ,Giva 1 Yas 25			Hispenic Origin? (Spean, Maxicen, Puarto Specify:	ecify Yas or No- Rican, atc.)	o- 14. Rece - Amarican Indien, Black, White, etc. Specify: White			
	ted	15. Dacedant's (Specify only highast	Education		16a. Deced	ant's Usual Occup	pation	rlm m	6b. Kind ot Bus			
	Completed	Elamantary/Secondary (0-12)	Coilaga (1-4	for 5+)			during most of work					
nt, th		17 Fethada Nama (First Middle La	2		Produ	cer	National Public Rad					
is marked other than aumatic event, the M	Be	17. Father's Neme (First, Middla, La Robert K. Dore										
s mark aumatic	2	19e. Informent's Name/Ralationship	***************************************	-	19h Mailin	n Address (Street	Victoria Tessier Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda)					
item 2 other		Robert K. Dore/F					ntal Street, Rockville, Maryland 208					
		20a. Mathod of Disposition		20b.	Diana of Dianas	dian /Ahma a ad	∞Jan. 10,			City or Town, State		
important: If it any injury or o		1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spa		Ga Ga	te of H	leaven Co	pring, Marylan					
any inje		21. Signeture of Funaral Service Like	censee	M001	Ro 198 3	Nama and Addre	Pumphrey Montgomer	Funeral	Home/Ro	ckville, Inc.		
		23a. Part . Enter the disease, or co shock, or heart failure. List on	omplicetions that cau	used the dae	th. Do not ante	ir the mode of dyi	ng, such es cardiac	or raspiretory erre	=2005 est,	Approximeta Intarval Batween		
sician				Onsat end Death								
dical niner		Immediata Ceusa (Final disease or condition rasulting in daath)		48 hours								
	-	Dua to (or es e consequence of):										
insit	Examiner	Sequentially list conditions. Dua to (or-as-d consequence of):								48 hours		
ial-tra	Exa	Sequantially list conditions, if any, leading to immadiete cause. Entar Underlying Cause (Disease or injury that initieted evants		Dua to (or as a consequ	uance of):						
s the burial-transit	edicai	Cause (Disaasa or injury thet initieted evants	or as e consequ	ence of):								
) O		resulting in death) Last	■ d									
e ettending	sicia	Part II. Other significant conditions	contributing to deat	th but not res	sulting in the un	dariving causa gir	van in Pert I.	23b. Did tol	23b. Did tobacco use contribute to the cau			
signed by me e	by Physician/N	A	cvosis					3 Probably 4 Unknow				
hes been signed 2 should t	Completed	Acute to	hepat	s tis				24e. Wes ar perform	autopsy ned?	24b. Ware autopsy findings eveileble prior to complation of cause of death?		
ate he	Con							1 □ Ye	s 2010	1 Yes 2 No		
	Be	25. Was cese ratarred to medicel examinar?	0 3-1				26. Placa of Deet	h (Check only one	1)			
S S	2	1 Yas 2 No			ER/Outpatient	3LI DOA		me 5 Rasida				
in the	lo.	27. Menner of Death 1 ☑ Natural 5 ☑ Panding	28a. Data ot (Month,	Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Dascribe ho	w injury occurre	d		
To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accidant Investigat 3 Suicida 6 Could not 4 Homicide determine	be 28a. Place of	Injury - At h , atc. (Specil	oma, tarm, stre	M 1 □	Yas 2□No	28t. Location (Str. City or Town,	eat and Numbe , Stete)	r or Rural Route Number,		
Funeral stely filled	edical C	29a. Certifiar 1 Certifying ! (Check only one) 2 Medical Ex	aminer: On the basi	s ot axamina	owledge, daeth ition and/or invi	occurred at tha ti	ma, date and plece, opinion, daath occurr	and dua to tha ca red at the time, de	usa(s) and man	nar as stated. nd due to tha ceuse(s)		
omply	Me	29b. Signatuyerand title of certifier	and manna	7 /	.0	29c. Licans	sa number	29	d. Dete signed.	(Month, Day, Year)		
-0) effry	4/0	elin	le w	D	47188 8240 VI		01/	08/98		
	-	30. Name and addrass of person wh										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** uller 5910 COON ben /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 DE Yrs. Director 73 28, 1924 Illinois 346-18-9223 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical France. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Llmits 1 ☐ Yes 2X No Directo MD Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10204 Folk Street 20902 Funeral USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Biack, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Completed by Specify 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Forrest V. Brown Agnes J. Scanlon 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14824 Bauer Drive, Rockville, MD Donald Brown (brother) 20353 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 1/16/98 Silver Spring, MD 22. Name end Address of Facility Francis J. Collins Funeral 21. Signeture of Euneral Service Licental Home Inc. 500 University Blvd. West 233 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. It only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner or Attending Physician: The lew requires that the death certificate be executed effer deeth.

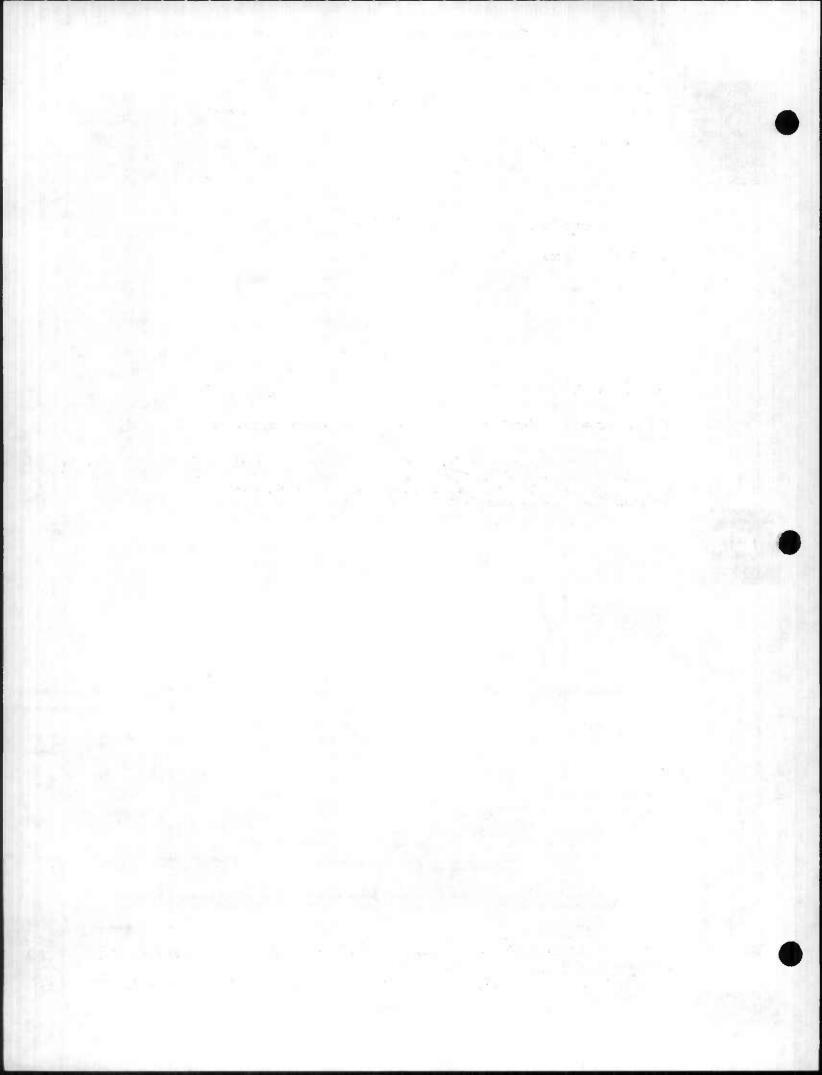
Director: After this certificate hes been signed by the ettending physician and buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Box 68760. physician Physician/Medical the Due to (or es e consequence of): signed by the etter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco uea contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably & Unknown Completed by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? should 24a. Wes en eutopsy periormed? director, Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) P Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturei 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide 24 hours e 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) To the Vithin 2 To the I complet 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 20 and 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8218 WISCONE 9 31. Dete filed (Month, Dey, Year) JAN 15 32. Registrer's Signature State

whice Davidson-Randall.

1998

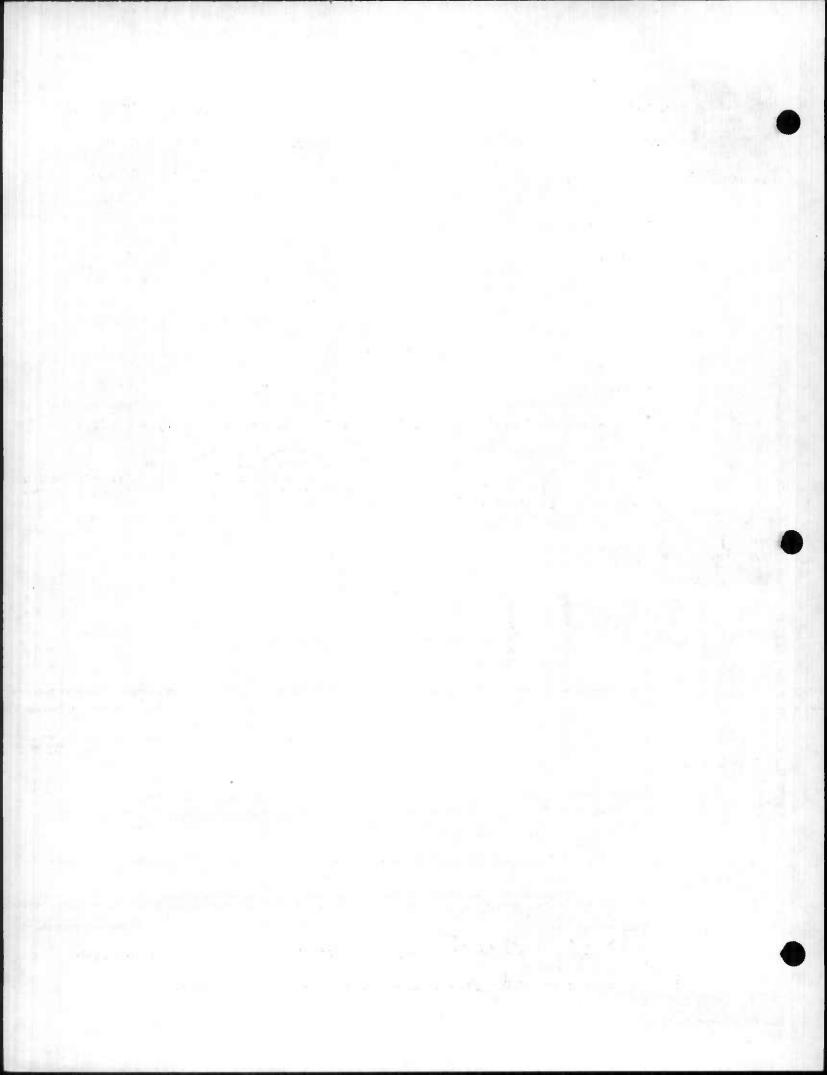
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 5

				C	Certificate o	f Death		Re	g. No.		
		1. Decedent's Name (First, Middle, I	ast)				2	. Date of Death	า		3. Time of Death
	rsiciar Iedical	1.0111 CA F1172DA	th Gilbert				J	Month	Day 13, 19	Year 98	10:55PM
	iedica iminei		ive street and number)			4b. City, To		tion of Death	4c. County		10.55111
(A. 1847)		Carriage Hill-	Bethesda			Bethe	esda		Monte	omer	o .
Fune	erai		Sex 7. Age (In	yrs. last birtho	(ay) If Under 1 Ya	ar If Under	24 Hrs. 8	. Date of Birth			place (Stata or Foreign htry)
Direc		020-26-5835 Usual Residence of Decedent	1□ M 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	95 Yrs	Months Day	/s Hours	Min.	(Month, Day, OV. 27,	1902	Czec	hoslovakia
arytan		10a. State 10b. County	100	c. City, Town o	r Location					1	Od. Inside City Limits
28a-f	Director	Maryland Montgom 10e. Street and Number	ery	Bethes	da 10f. Zip Code			10	g. Citizan of V	Vhat Cour	1 ☐ Yes 2X No
death with the Maryland			ne		2081				Jnited		
ab a	Financial	11. Marital Status	12. Was Decedent Evar Armed Forces?	in U,S.	 Was Decedent of If Yes, specify C 	f Hispanic Or	igln? (Speci	fy Yes or No-		e - Americ	cen Indian,
15-0020 72 hours after death with the Marylar reatural, or thems 23s or 28e-f show	h vd	3	1 ☐ Yas 2 🛣 No If Yes, Give Year or Dates:			☐ Yes 2 No Specify:		,,	Specify		ite
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural" or	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. De	ecedent's Usual Occ ive kind of work doi fe. DO NOT use ret	cupation ne during mos	at of working	1	6b. Kind of Bu		
212 within jens.	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		e. <i>DO NOT</i> use ret rtist	ired)			Portrait		ainting
D ST	B G	17. Father's Name (First, Middle, Las	()	1 41	TCIBC	18. Mother's Name (First				arneing	
ylan ylan Mental arked o	TO B	Bernhard Ohs				Poss	Löwe	nthol		rf.	
and M	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Stre				City or Town	State Zin	Code)
and 2		Renée S. Rizzon			1 Honeybe						
re,		20a. Method of Disposition		b. Place of Di	sposition (Name of			1	Oc. Location -		20817 own, Stata
0 0 0 - 1		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ity)	cematery, Montgom	crematory or other parents	Janua Janua torium	ry 15	1			aryland
Baltim pemit. Pag Department Important: I	SUCE	21. Signature of Fundral Service Lion	n pea		22. Name and Add	fress of Facili	y Robe	rt A. F	umphre	y Fu	neral Home
_		23a. Part1. Enter the disease or cor	nollcations that days ad the	100803	Bethesda,	Mary1	and	20814-3	3501		onsin Avenue
Physici	an	23a. Part1. Enter the disease, or cor shock, or heart failura. List only	one cause on each line.	addin, Donot	onto the mode of c	ying, such as	COTORAC OF I	espiratory arra:	51,	-	Approximata Interval Between Onset end Death
/Medic		Immediate Cause (Final	Comphus	1 77	lar Accid						0 ** 1
Examir	ner	disaase or condition resulting in death)	a.			lenc				i	2 Weeks
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uted	Examiner	Sequentially list conditions	b. Due	to (or as a con	sequence of):					1	
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68760, fficate be ex	cai	Cause (Disease or Injury thet Initiated events resulting in death) Last Due to (or as a consequance of):									
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that the death cered by the attendir detached for use	Physician	Doet II. Othou plantificant conditions									
that the defected	hys	Part II. Other significant conditions	contributing to death but not	resulting in th	a underlying ceuse	given in Part i			the cause of death?		
S, T s that med b	by P		sease					1 1 70	8 ZAJNO	3 Prot	bebly 4 🗆 Unknown
Of VICAL RECORDS, P. Physician: The law requires that this certificate has been signed it all director, page 2 should be det	Completed							24a. Was an perform		ava	ara autopsy findings ailable prior to mpletion of ceuse death?
The law rate has to page 2 s	omo							1 ☐ Yes	2 No		Yes Z No
VICIAN: The certificate rector, page	Be	25. Was case referred to medical				26. Place	of Death (Check only one)		
OI VILE Physician: this certific and director.			Hospital:	2 ER/Outpa	tient 3 DOA	other		5 ☐ Residen		er (Specifi	v)
g Physical distribution			28e. Dete of Injury (Month, Day Yea	28b. Time	e of 28c. In			d. Describe hov			,
Attending or death. Sector: After by the fune	atio	1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	n	(r) Injur		Yes 2	No				
	Certification:	3 Suicide 6 Could not I determined	28e. Place of Injury - building, etc. (Sp	At home, farm,	street, factory, offic	9	28f	Location (Stre City or Town,		er or Rura	l Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	caic		nysician: To the best of my	knowledge, de	eath occurred at the	time, date en	d place, and	due to the ceu	use(s) and mai	nnar es st	ated.
the H iin 24 the F	edicai		miner: On the basis of exam	nination and/oi	Investigation, in my	opinion, dea	th occurred	at the time, dat	te and place, a	nd dua to	the ceuse(s)
0 T W 0 D	Σ	29b. Signature and Wer of certifier	1/ -	/	29c. Lica	nsa number		296	d. Data signed	(Month,	Day, Year)
12		Lee &	. Honning	Do as	10 D2	1115		Ja	nuary	14. 1	1998
,		30. Name and address of person who	completed ceuse of death	(Item 23a) (Typ				10.4		- ' '	
		Lee R. Penningt	on, M.D. 560	2 Shie	lds Drive	, Beth	esda,	Mary1a	nd 20	817	
	State	31. Date filed (Month, Day, Year) JAN 1 5 1	32. Renistrar's S	ignature			17-1				
Reg	istrar	JANIS	998 Julia Da	udson-A	indell						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Dey Month **Physician** Jean P. Gallagher January 8, 1998 8:20 PM /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year Age (In yrs. last birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Days 1□ M 2☑ F Yrs. Director 524-01-5248 81 Jan. 29, 1916 Colorado Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be nottined at 1⊠ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a 403 Russell Avenue, Apt. 604 20877 United States deeth Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 Yes 2 No Specify: Specify: þ 3 ₩idowed 4 Divorced White "naturef" Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Housewife Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health end Mentel Heart: If Item 27 is marked oth jury or other traumatic evan Be 2 Ress Philips Essie Heath 19a. Interment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5394 Millwood Drive, Gloucester, Virginia 23061 Joseph Andrew Gallagher/Son Baltimore. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Jan. 11, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service License 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01126 plication that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** The lew requires that the death certificete be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest buriel-tran pue Physician/Medical the Due to (or es e consequence of) Box (use P.O. I Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 99 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? page 2 should Completed 24a. Wes an eutopsy 1 ☐ Yes 2 No 1 Yes 2 No this certificate of Vital ial or Attending Physician: Tres after death.

In Director: After this certificate ed in by the funerel director, pa Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Manner of Death Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

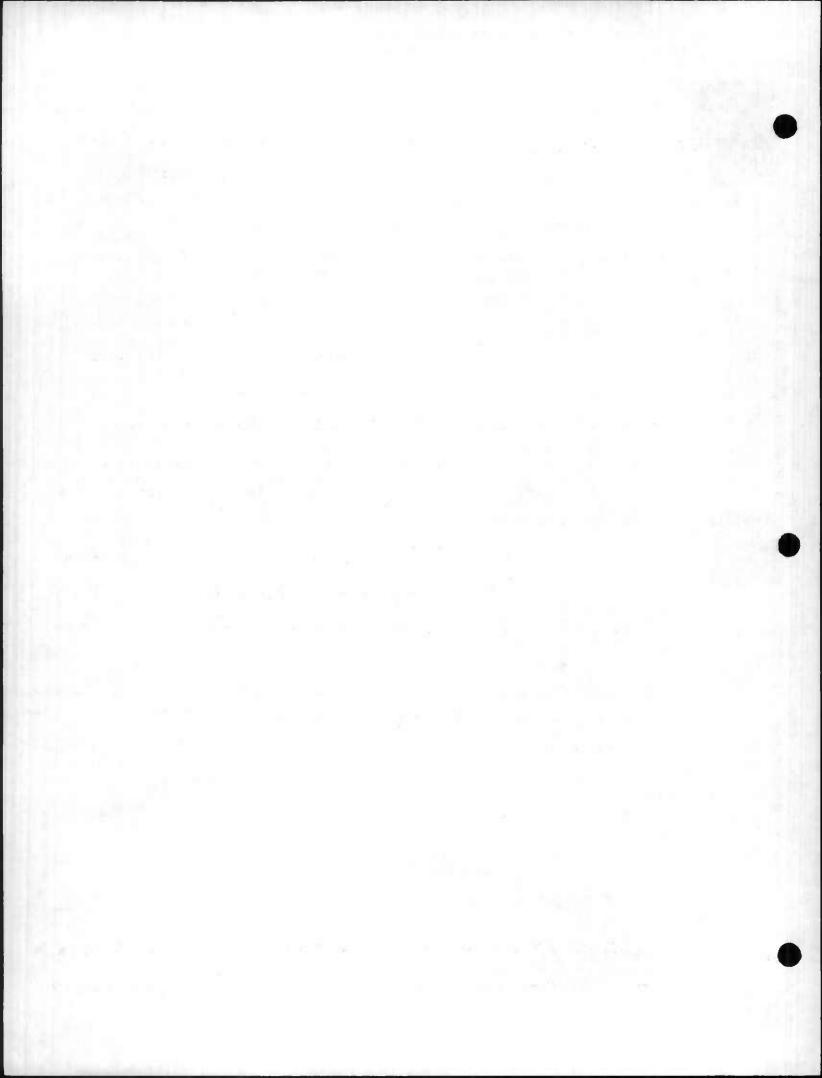
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Muna M D15046 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 1926/ Montgarrery Village Are. Gasters buy Mel 20879

32 degistrar's Signeture

Registrar

State

STEPHEN J NEWMAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death HORACE G. GARRETT, **Physician** 10:45 am 14 JAN. /Medical 4c. County of Deeth 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Montgomery Rockville Rockville Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Birthplace (State or Foreign Country) 1XXM 2 F Months Deys 80 408-07-8742 May 22, 1917 Director Tennessee Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Rockville Montgomery Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 199 Rollins Avenue, Apt. 426 20852 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. filed withIn 72 hours efter NYes 2 No 943-If Yes, Give 1943-Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) tel Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Sales Representative Electrical Appliances permit. Peges 1 and 2 should be file Department of Health and Mentel Hy important: If flem 27 is marked othe any Injury or other traumatic event, other. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Horace Greeley Garrett, Sr. Nan Ransom 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20852 199 Rollins Avenue, Apt. 426, Rockville, MD (Wife) Dove B. Garrett 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 Removel from State 1-15-98 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P.A. 21. Signeture of Funeral Service Licenses 20910 933 Gist Avenue, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physicien end for use es the buriel-trensit 0 The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as a consequence of) P.O. Box 68760. Due to (or es e consequence of): resulting in death) Lest Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 90 24b. Were autopsy findings Completed 24a. Was en eutopsy eveileble prior to completion of ceuse of death? performed? hes 1 Yas 2 N No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was casa raferred to medical 26. Placa of Death (Check only one) Hospital: Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manper of Deal Certification: 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending Investigation efter deeth.

Director: Aff
d in by the fu 1 Yes 2 🗌 No 6 Could not be 3 Suicide 28e. Placa of fnjury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Certifying Phyaician: To the best of my knowledge, death occurred at the tima, data end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. edicai 29a Certifian 29b. Sig ature and title of Sertifier 29c. License number 29d. Dete sign (Month, Day, Year) Jun 17

50 West Edmonston Drive, #207, Rockville, Maryland

20852

Bun

State Registrar Paul

31. Date filed (Mont

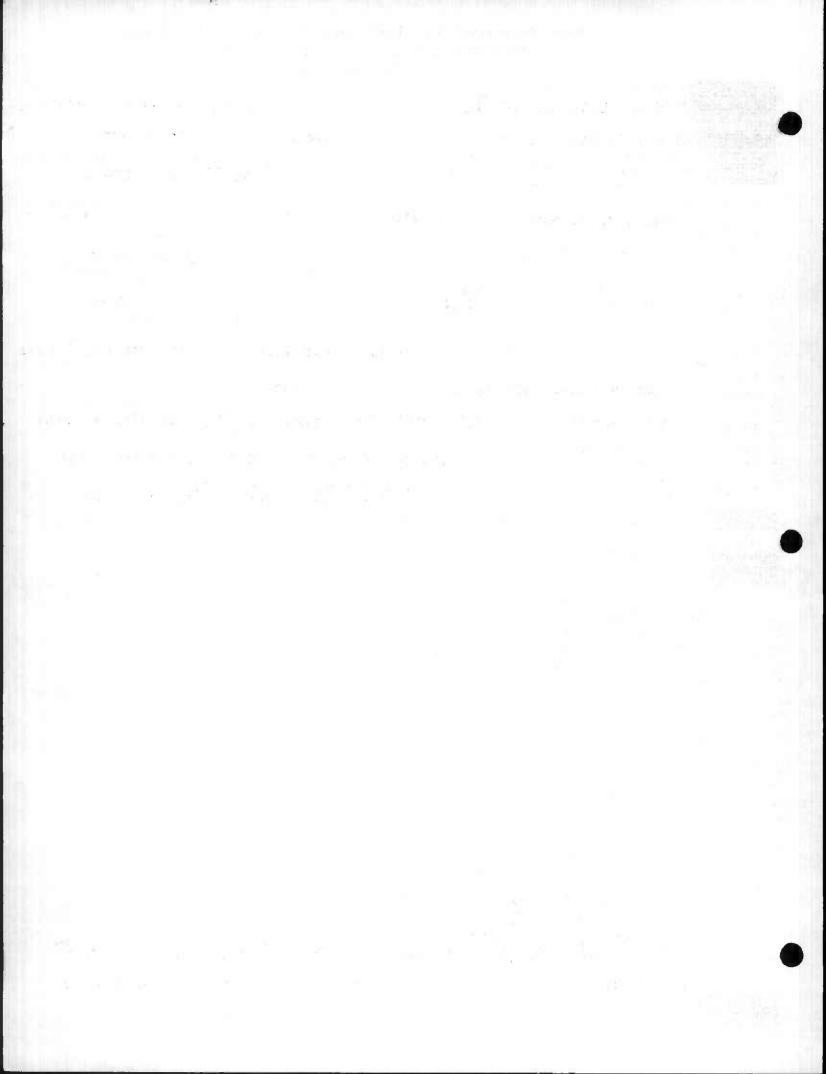
T. Noone,

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sina Davidson-Randols

M.D.

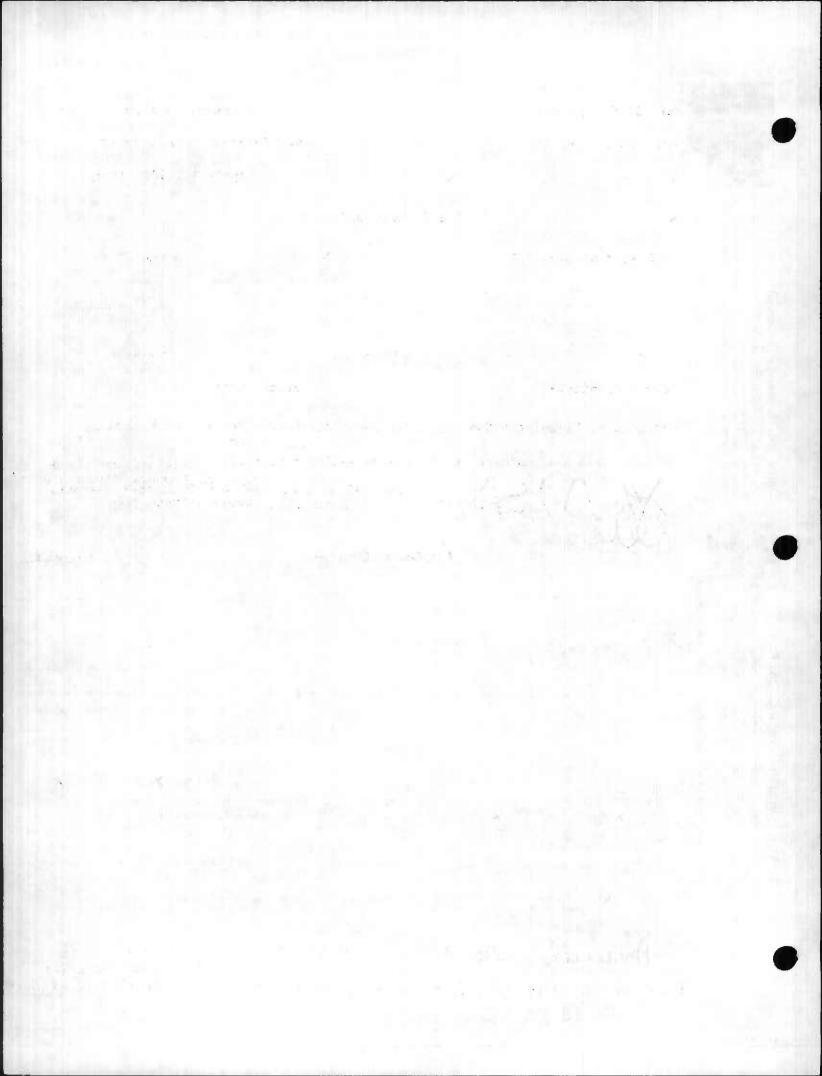


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:10 AM Mary J. Giampietro 6, 1998 January /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□M 2\ F Yrs. 97 April 18,1900 Director Italy 579-10-0171 Usual Residence of Decedent the Meryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Meryler than Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examinat must be notified at Washington, D.C. 1☑ Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 32nd Street, 20020 United States S.E. Funeral 14. Reca - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 18 Mother's Name (First Middle Malden Sumeme) 17. Father's Name (First, Middle, Last) Cianciola Adam Cardinale Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traur 12715 Robindale Drive, Rockville, MD 20853 Dominick M. Giampietro/Son 20b. Place of Disposition (Neme of cametery, crematory or other plece) Jan. 10, 1998 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 ☑ Other (Specify) Entombment Washington National Cemetery Suitland, Maryland 22. Name end Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Inc. 400689 Rockville, Maryland 20850-2805 Rockville, Maryland 20 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) In eu monta week Examiner Due to (or as a consequence of): Examiner sician and burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): attending physician for use as the bune Box 68760 Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🐼 Unknown þ 24b. Were autopsy findings eveilable prior to 24a. Was an autopsy performed? Completed been : completion of cause of death? has 1 Yes 2000 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 KInpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred or Attending Pi efter deeth. Director: After ti 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Cartifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

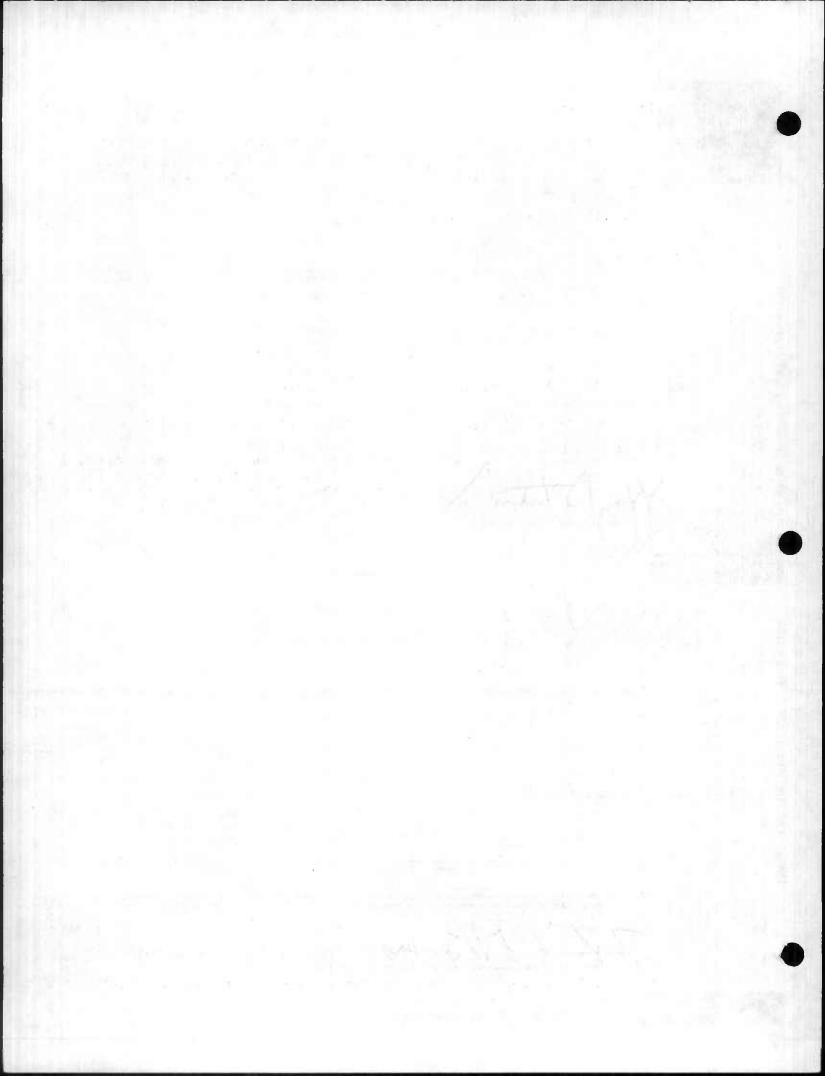
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartified malo MD JAN 6 12 Silver Spring MD 20910 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) . Go KAISER office Holy Cross Hospital Isoo Forest 9km & 32. Registrar's Signature State Tichia Davidson-Randoll

Registrar

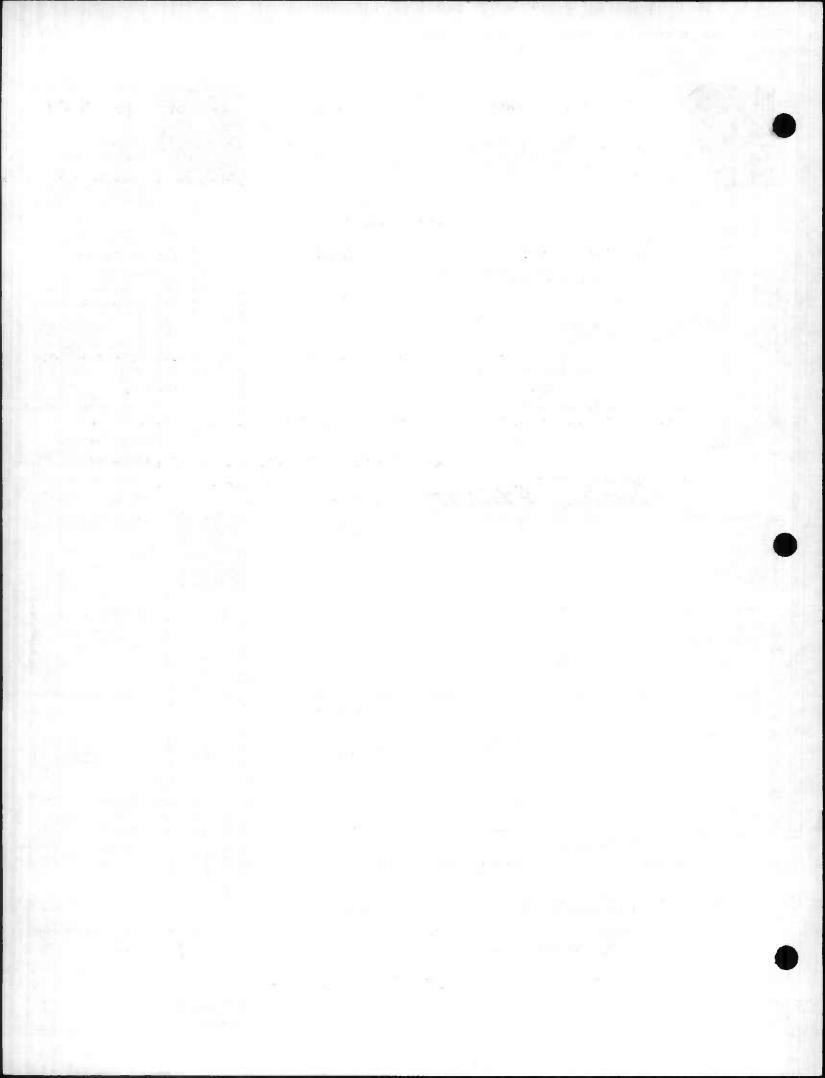


State of Maryland / Department of Health and Mental Hygiene 8 0 1899

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Ŧ			30. Neme end address of person who											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month AUBURN T. GRAY 0927 JANVARY /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MO If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Yeer) Jul 5,1938 MONTGOMERY 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1**½** M 2□ F Months Deys 59 Director 213-38-0623 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Mas 2□No Director Md Montgomery Gaithersburg 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 5 items 23a 9407 Merust Lane U.S.A. 20879 Funeral 12. Was Decadent Ever in U,S. Armed Forces? 14. Rece - Amarican Indien, Black, White, etc. Wes Decadant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yas 2 ②No If Yes, Give Yaar or Dates: ŏ 1 Yes 2 No Specify: by Specify: 3 Widowad 4 Divorced "natural" Black Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry xe filed within 7 al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 10th Grade Auto Salesman Automotive 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surneme) Be h end Mental I Alfred Hackey Gray Florence 19e. Informent's Name/Reletionship (Type, Print) (Wif∈) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2
Depertment of Health es
Important: If Item 27 is: 9407 Merust Lane, Gaithersburg, Md 20879 Maude O. Gray 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stata Metropolitan Crematory 1/7/98 Alexandria, VA 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md tions thet caused the daath. Do not enter the mode of dying, such as cardiac or raspiretory errast, cause on each line. 23a. Pert1. Enter the disease, or complice shock, or haart failure. List only on Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting In deeth) Lest Due to (or es e consequence of) Physician/Medical Dua to (or as a consequanca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Completed 24e. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medicel exeminer? 26. Piece of Death (Check only one) exeminer?
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27. Manner of Deeth Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. tnjury et Work? Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide

physician end s the burial-trans Box 68760. 2 for use as P.O. the 5 signed b Records. page 2 s Division of Vital or Attending Physician: After efter deeth.

Director: After d in by the fun To the Hospital or within 24 hours eft To the Funeral Dil completely filled in

72 hours efter

Baltimore, Maryland 21215-0020

6 Could not be determined 28f. Location (Street end Numbar or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steted. 29a. Certifier 29b. Signature end title of certifier

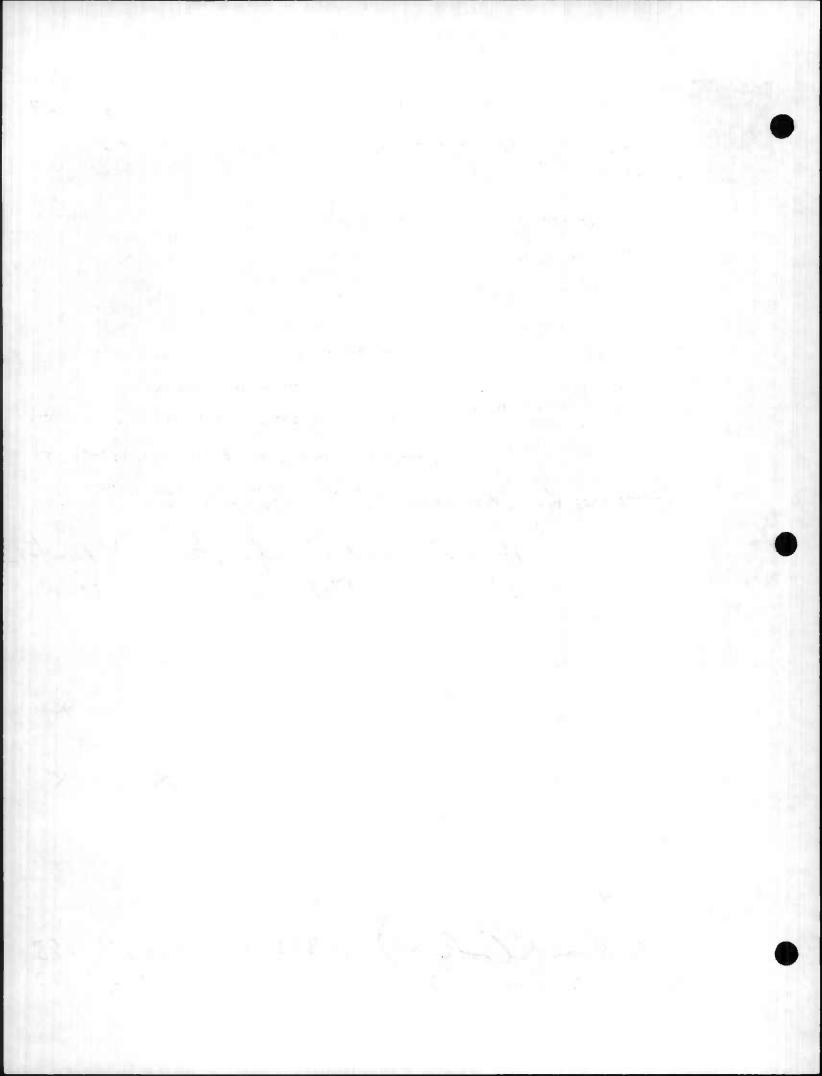
29c. License number 29d. Date signed (Month, Day, Year)

d cause of deeth (Jem 23e) (Type, Print) Shady Grove Adv. Hespooley

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State Registrar

Medical

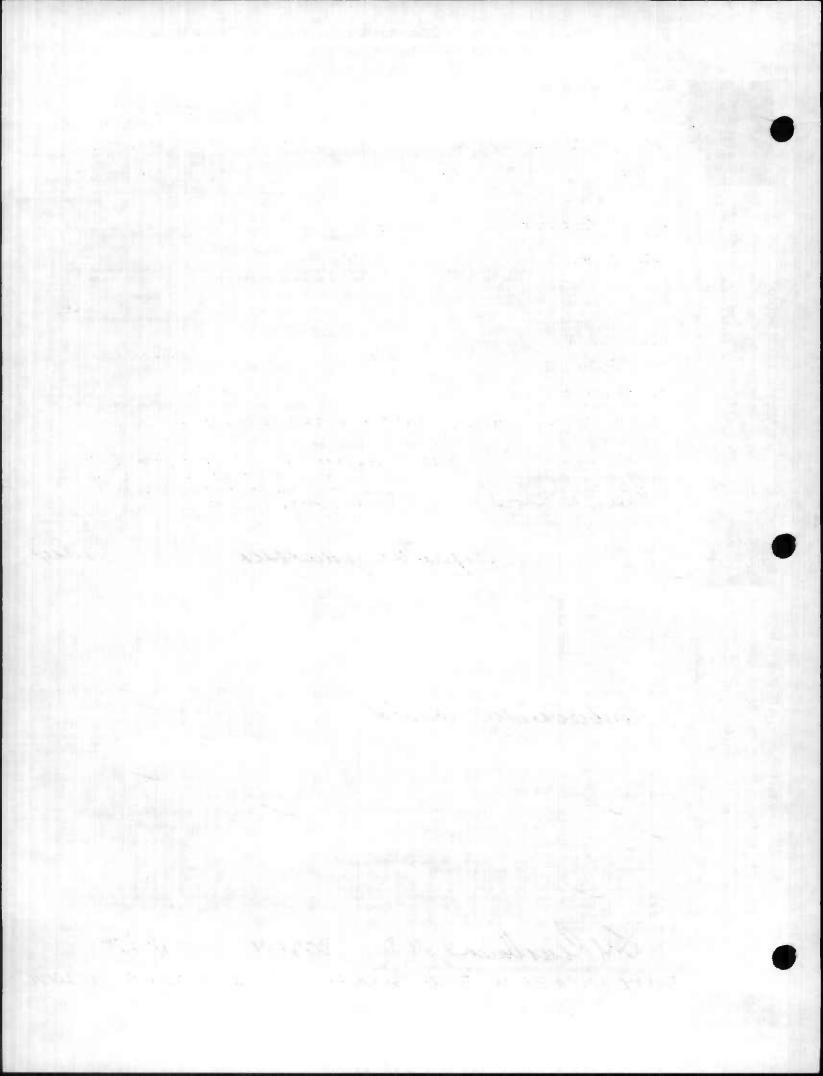


State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Daeth 3. Time of Death Month **Physician** Alice E. Graziani 11, 1998 January 11:00 AM /Medical 4b. City, Town, or Location of Daath 4a Fecility Nema (If not institution, give street end number) 4c. County of Death Examiner Randolph Hills Nursing Home Montgomery Wheaton If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Numbar 7. Aga (In yrs. last birthdey) 6. Sax 8. Data of Birth (Month, Dey, Yeer) Birthpleca (State or Foreign Country) **Funeral** 1□ M 2□ F Months Deys Hours Min. Yrs. 579-07-4163 83 Director Feb. 11, 1914 Maryland Usual Rasidance of Dacedani with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director MD Montgomery Silver Spring 10e. Street end Number 10g. Citizan of What Country? 10f. Zip Coda ò 238 14400 Homecrest Road 20906 USA Funeral 72 hours after deeth items 12. Wes Dacedent Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 6 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry pernit. Peges 1 end 2 should be filed within 7 Department of Health end Mantal Hygiene. Important: if fem 27 is marked other than *r any Injury or other traumetic event, ## Med ping. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Clerk U.S. Government 17. Father's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be 10 Angelo Graziani Ethel Powell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James L. Towles 4705 Bel PRe Road, Rockville, MD 20853 (nephew) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemetery 1/14/98 Brentwood, MD 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funaral Sarvice Licen Home, Inc. 500 University Blvd. West 23a. Pert1. Enter the diseese, or complications that causad tha deeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line. Approximata intarval Batween Onsat and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) Quentica /Medical Examiner Examiner physician end s the buriel-transit certificata be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in deeth) Lest Dua to (or as a consaquance of) Box 68760 Physician/Medicai Due to (or es e consequança of) Se 950 for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the datached signed by t 1 Yes 2 No 3 Probably 4 Unknown oretrocraxulae Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen page 2 has 1 Yas 2 AN 1 ☐ Yas 2 ☐ No certificate funaral director, Be 25. Was case referred to medical axaminar? 26. Placa of Daath (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Daath 28c. Injury at Work? 28d. Dascribe how injury occurrad 28b. Tima of 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding invastigation i or Attending after death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 D Homicida To the Hospital within 24 hours a To the Funeral C Hospital edicai 29a. Cartifian 1 Certifying Physician: To tha bast of my knowledge, daeth occurred et tha time, date end piece, end due to the cause(s) and manner es stated. completely (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceusa(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) FARRAGUT AVE KENSING FON, MI 20191 ROSEN BAUM 3720

State Registrar 31. Data filed (Month, Dey, Year) JAN 13

32. Ragistrar's Signatura Julia Davidson-Randoll

Brun



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Dolores E. Gray January 8, 1998 11:16am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery General Hospital 01ney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2型 F Yrs 91 **Director** 287-22-1719 Oct. 27, 1906 Ohio Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director than "natural", or items 23s or 25s-f : the Medical Examinar must be notifie Maryland | Montgomery Silver Spring 10e Street end Number 10f Zin Code 10g. Citizen of Whet Country? 15100 Interlachen Drive #117 20906 Funeral United States 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: P 3 ଐ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiens. ther then Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 2 should be f h and Mental H is marked of Lewis A. Gray Bessie Mae Unknown permit. Pages 1 and 2 sh. Department of Health and A. Important: if them 27 is many injury or other control of the control of 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Richard Simons/Friend 20113 Darlington Dr., Gaithersburg, MD. 20879 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriai 2 ☼ Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Metropolitan Crematory 1/9/1998 Alexandria, VA. 21. Signature of Funeral Servica Licensee 22. Name end Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician tmmedlete Ceuse (Final diseese or condition resulting in deeth) /Medical arologenic Examiner Examine myozarvial Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last asheroschors Coronans Physician/Medical Due to (or as a consequenca of) 98 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? in and con 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown unpertensin þ Completed 24a. Was en eutopsy 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 Denturel 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

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Baltimore, Maryland 21215-0020

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1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end placa, end due to the cause(s) end manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year) January 8, 1998

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 3801 International Dr., Silver Spring

31. Date filed (Month, Day, Year) JAN 13 1998

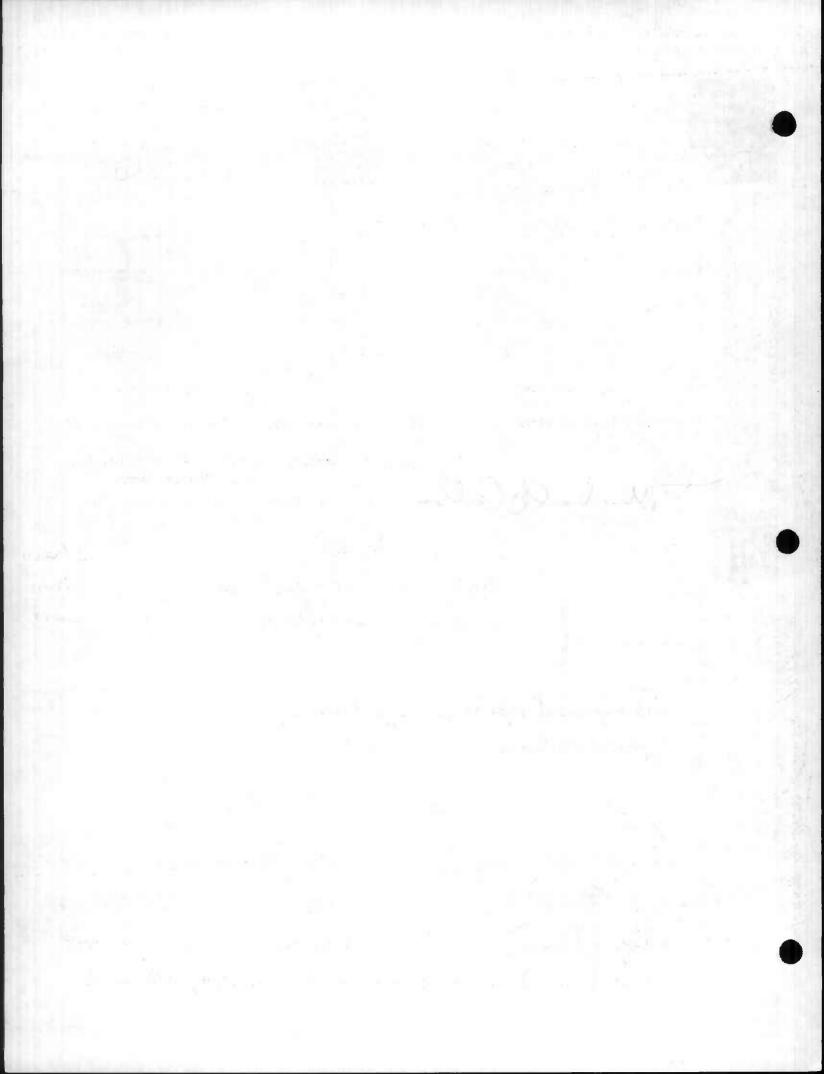
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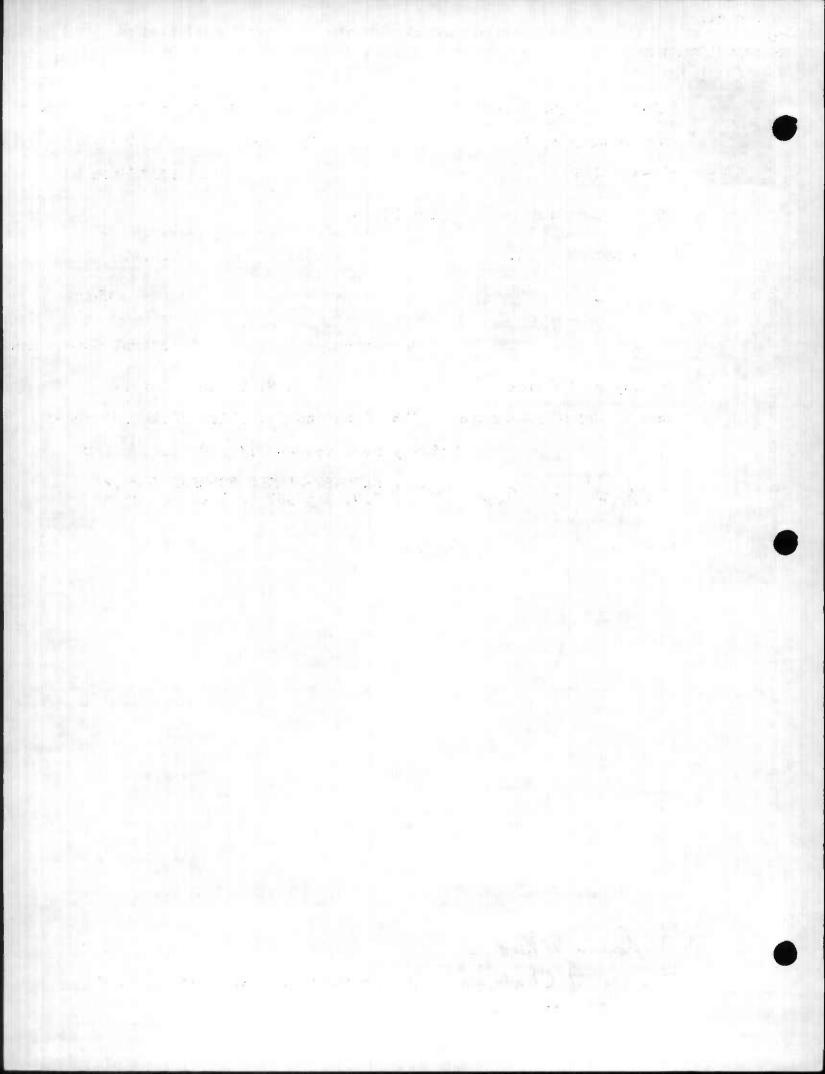
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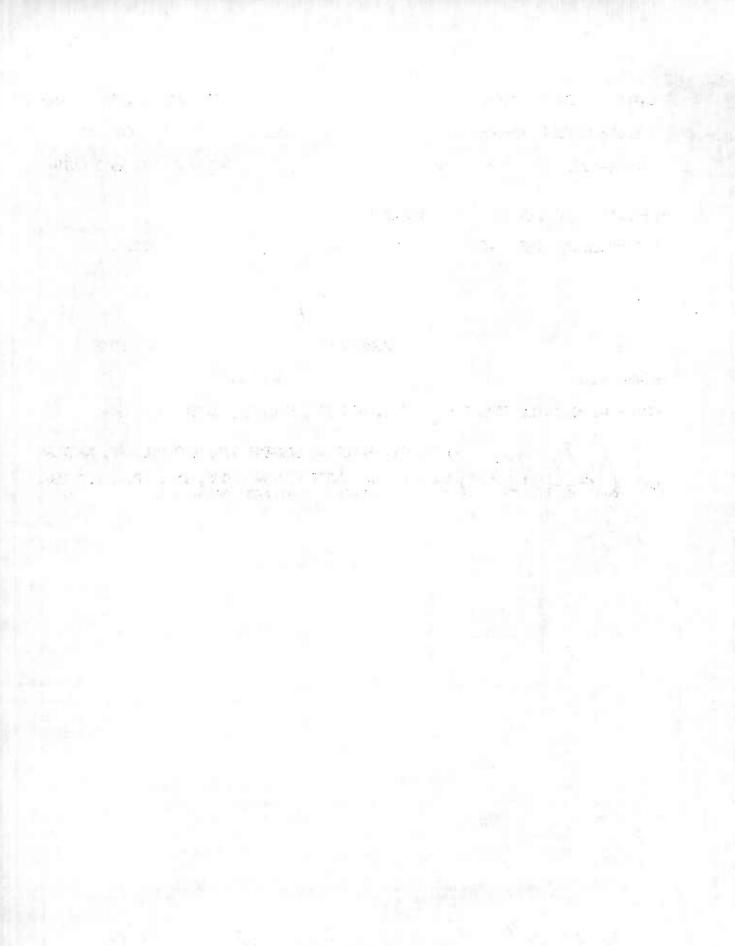
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** CATHRYN JOAN **GARNER** JANUARY 5, 1998 6:45 PM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner WALDORF HEALTH CARE CENTER WALDORF **CHARLES** 8. Data of Birth 9. Birthplaca (S (Month, Day, Year) 9. Birthplaca (S NOVEMBER 25, 1911 OH10 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Months 1 ☐ M 2 🕶 F Yrs. Director 578-12-2581 86 Usual Rasidance of Decedant tha Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f shov Examiner must be notified at 1 ☐ Yas XIX No Directo MARYLAND **CHARLES** WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 permit. Pages 1 and 2 should be filed within 72 hours efter death with Deportment of Heelih end Mental Hygiene. Important: If Item 27 is marked other than "" any injury or other traument of the page. 2375 UNCLE WILLIES PLACE 23a 20601 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black White atc 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva 1 ☐ Yas 2 No à Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11 OWN HOME 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) GEORGE EING MARY BALDY 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ESTHER M. SHERWELL/DAUGHTER P.O. BOX 331, WALDORF, MARYLAND 20604 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 4 Donati Cramation 3 Ramoval from State 5 Othar (Spacify) TRINITY MEMORIAL GARDENS 1/8/1998 WALDORF, MARYLAND unara Sarrice Lich 21. Signatura THE HUNTT FUNERAL HOME, INC., P.O. BOX 156, MARK G. **BROHAWN** M00053 WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medicai Immadiata Causa (Final disaasa or condition resulting in death) Examine Examiner The law requires that tha death certificete be axecuted Sequantially list conditions, if eny, laading to Immadiata causa. Entar Underlying Cause (Diseesa or Injury that initiated avants rasulting in daath) Last Dua to (d) as a consaquence of): physician e Box 68760. Physician/Medical Dua to (or as a consequance of): attending for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Ware sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate hes b director, pege 2 s 1 Yas 2 12 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after daath.
Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was casa rafarrad to medical axeminar? Be 26. Placa of Death (Check only ona) 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) P 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manney of Deeth Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 DNaturel 5 Panding 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 24 hours To the Hosp within 24 hou To the Funer completely fil Medical 29a. Cartifian 12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaer) 30. Nama and address of person who complated cause of daath (Itam 23a) (Type, Print) MICHAEL A. LEATHERWOOD, MD., P.O.BOX 249 WALDORF, MARYLAND

State Registrar

JAN 1 3 1998

31. Data filed (Month, Day, Yaar)

32. Registrar's Signatura ali Storilor Randall 20604



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 10, 1998 Hazel Marie Bennett. Griffin January 6:40 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Dete of Birth (Month, Dey, Year) March 3, 1917 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
NEW YORK 7. Age (In yrs. last birthdey) 1□ M 2♥ F Months Hours 133-26-4947 80 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 HNo Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20814 5202 Danbury Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Library of Congress 5+ 12 Section Head 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Griffin Barbara S. Bennett Benjamin Terry 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Carroll G. Noll (POA) Same as 10 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burlel 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1-11-98 Beltsville, Maryland Chesapeake Crematory 22. Name end Address of Fecility
Rapp Funeral Services, P. A. 21. Signeture of Funeral Service Licensee)lee 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel Pancreatitis 3 days diseese or condition resulting in deeth) Due to (or es e consequence of): Examiner Cholelithiasis Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes ACKNo 3 Probably 4 Unknown Rheumatoid Arthritis à 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1 ⅓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier Medical

Box 68760 P.O. Records, Division of Vital or Attanding Physicism: **Funeral**

Director

7 is marked other than "natural", or items 23s or 28s4 show trsumstic event, the Medical Evanning must be notified at

the Maryland

72 hours after

permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: if I tem 27 Is marked other than 'n any Injury or other traumatic

Physician /Medical

Examiner

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page 2 hes

Baltimore, Maryland 21215-0020

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To the Hospital of within 24 hours of To the Funeral D

29b. Signature end title of certifier Varney, 29c. License number

29d. Date signed (Month, Dey, Year)

D 20332

January 10, 1998

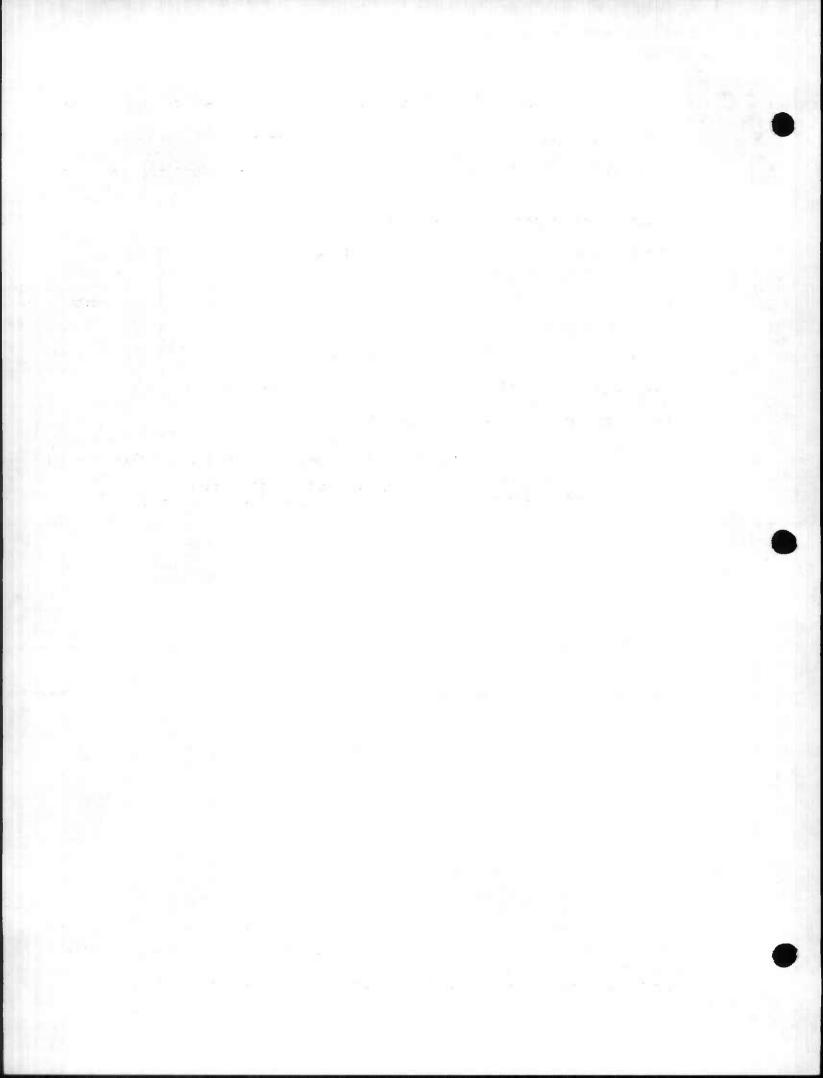
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Robert H. Varney, M. D., 9715 Medical Center Drive, Rockville, MD 31. Dete filed (Month, Dey, Yeer)

State Registrar

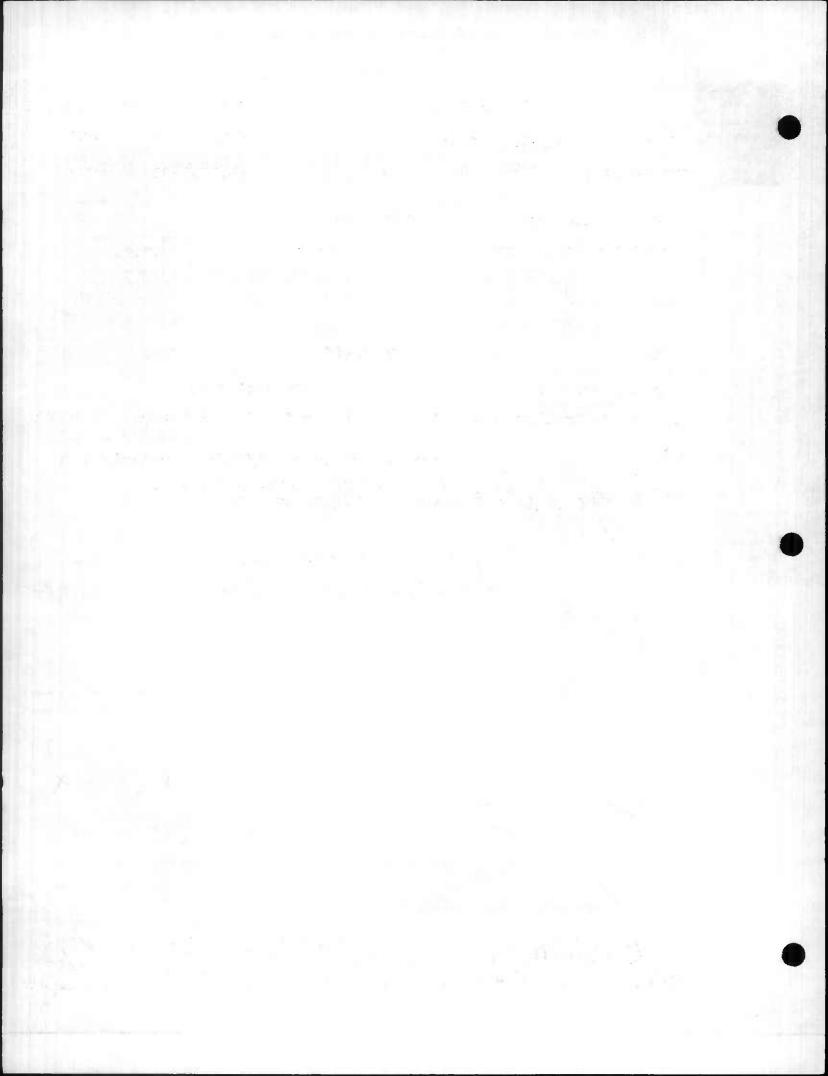
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32. Registrer's Signature hera Davidson-Randose



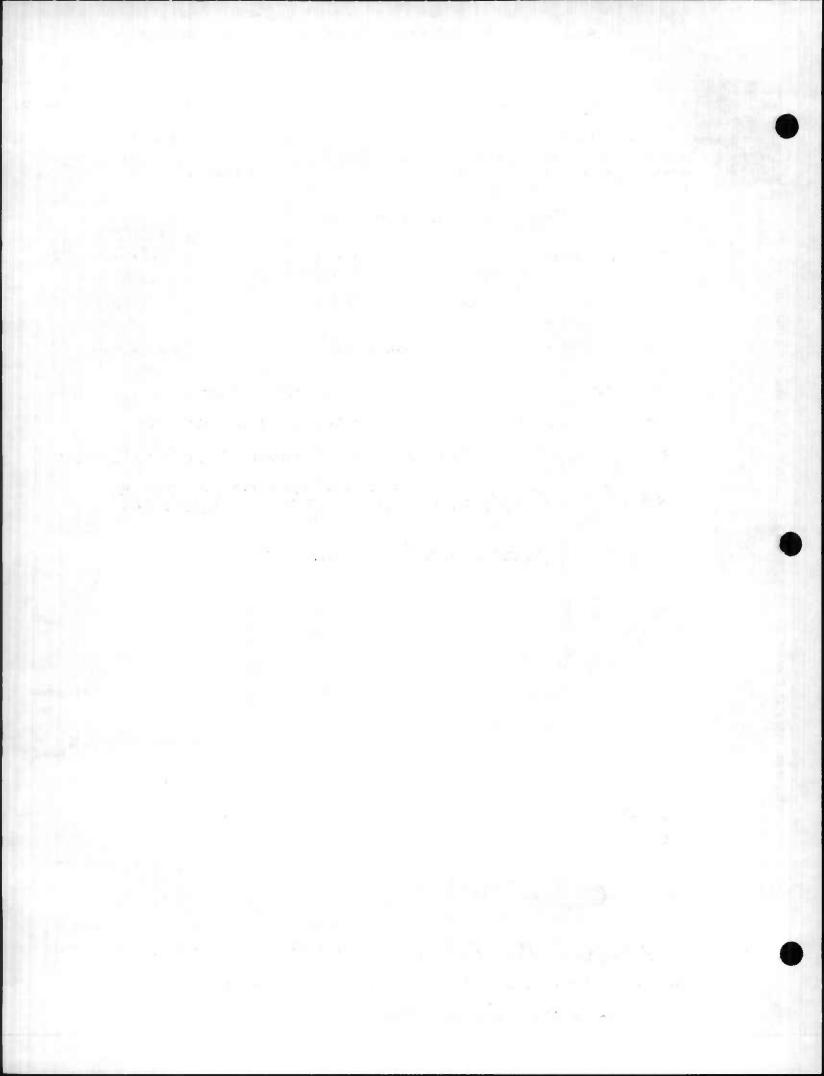
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Physician/M	Pe	ort II. Other elgni	ficant condit	tions contrib	outing to deat	h but not res	ulting in the ur	nderlying	cause giv	en in Pert L	23b. Did	tobacco uee co	entribute to	the caus	e of deati
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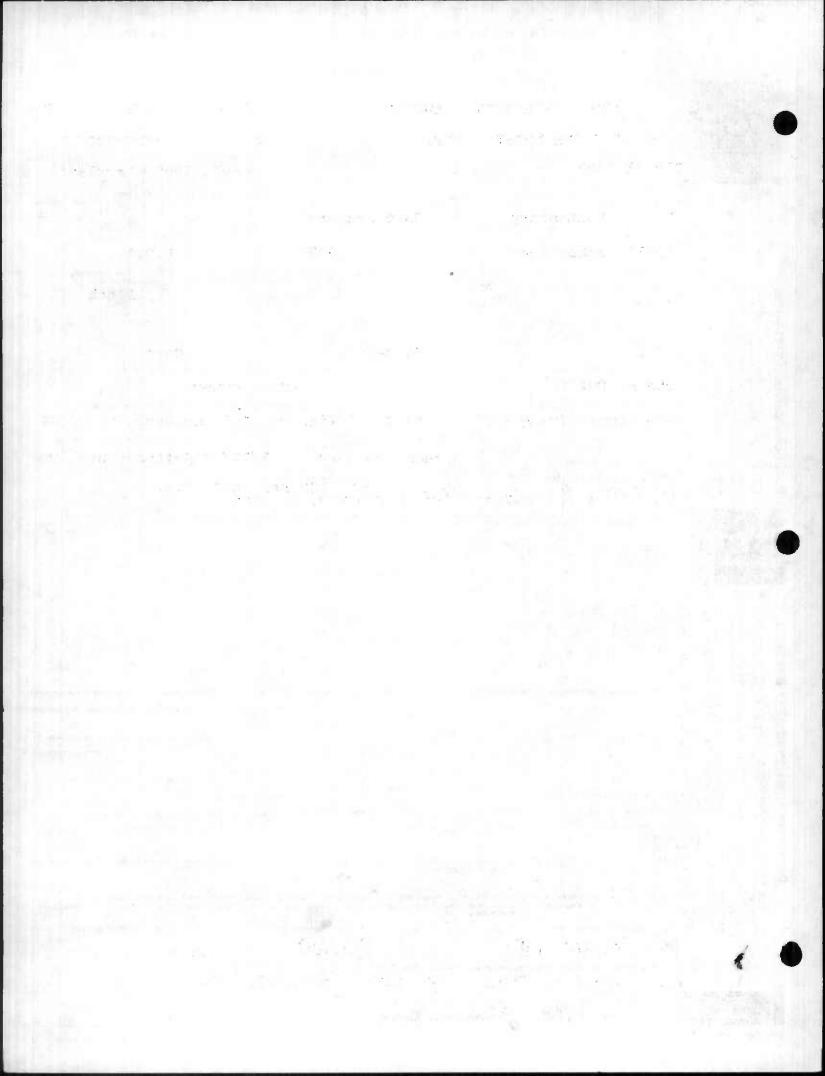
State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La	st)			Certificate o	Doam	2. Dete of Dea		U	3. Time of Death
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Examir	_	4a. Facility Name (If not institution, give 9230 5ht STREE					4b. City, Town, or I		4c. County CHARL		
Funeral Director		5. Social Security Number 6. S 579-18-3943 Usual Residence of Decedent	Sex 7. Agu	7 4	. lest birth Y	if Under 1 Yearns. Months Day		8. Date of Birth Month, Dey March	1 ^{'8''} 192	9. Birthple 3 Countr	ce (Stete or Foreign y) NC
Nano.		10a. State 10b. County		10c. C	ity, Town	or Location				10	d. Inside City Limits
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natural',	Completed	15. Decedent's Ed (Specify only highest gra	ducation	74.44		Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	upation	kina	16b. Kind of Bu	siness/Indu	stry
than the	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)		life. DO NOT use reti Mechanic		Awig	Morro		
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Mental Merked of	To Be	Olin Hunter								,	
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Health ar tam 27 is other trat		Dorothy Hunter				0. Box 3					
nent of Health ant: If item 27 ury or other to		20e. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State	20b.	ent and I	Disposition (Name of cremetory or other p		_			rf, MD
Department of Important: If it any Injury or one		21. Signature of Funeral Service Licer	11 1	00M	945	AREHART	ress of Fecility -ECHOLS x 567 La	FUNERA	L HOME	, PA	
hysician /Medical Examiner	-	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	a. PROSTAT	E C	CANC	ER WITH I			est,	1 1	Approximate nterval Between Onset and Death
ding physician end se as the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			onsequence of):					
intos intat inte ocean cer signed by the ettendin id be detached for use	hysician	Part II. Other significent conditions of	ontributing to death bu	ıt not re	sulting In	the underlying cause	given in Part I.				he cause of death
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ls certificete director, pag	Be	25. Was case referred to medical examiner?	11					th (Check only or	е)		
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of Americany effer death. Director: Affer in by the fune	Certification:	1 Natural 5 Pending investigation 3 Sulcide 4 Homicide	0 00- 01(1-1	ıry - At I	In nome, farr	ury W	☐ Yes 2 ☐ No	28f. Location (S. City or Town	reet and Numb		Route Number,
within 24 hours	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysicien: To the best of niner: On the basis of end manner sta	examin	owledge, ation and	death occurred at the for Investigation, In my	time, date end place oplnion, death occu	, end due to the c rred et the time, d	euse(s) end ma ate and place, e	nner es ste and due to t	ted. he cause(s)
withir To th	M	29b. Signeture and title of certifier				29c. Lice	nse number	2	9d. Date signed	(Month, D	ey, Year)
		pouls.	M. 1	70	ha	D	28352	i	ANUAR	Y 12,	1998
	1	30. Name end address of person who	completed cause of de	eath (Ite	m 23a) (1	vpe, Print)					
		KRISHAN MATHUI). B		LA PLAT	A, MD	20646		



State of Maryland / Department of Health and Mental Hygiene

Physici	an	1. Decedant's Nama (First, Middle, Las	t)						2. Data of Dea Month	eg. No.	Yaer	3. Tima of Deet	
/Medi			JIRGINIA		AWKIN	IS			JANUARY		198	15:52 BU	
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uneral irector		213 01 0033	ax □ M 2 🔀 F	91	est birthday) Yrs.	Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Birth May 7,	1906	9. Birthp Cour Mar	lace (State or For try Vland	
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0 pe	To Be	John H. Duffin							ne (First, Middle, I Turner		n <i>e)</i>		
s mark aumati	Ĭ	19a. Informant's Name/Ralationship (T	vne Print)		19h Mailin	a Addres	es (Stroot		iral Route Number		State Zie	Codo)	
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Department of Heelth and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, once.		20a. Method of Disposition 20b. Placa of Disposition (Neme of Data 20c. Location - C										n - City or Town, State	
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		4 Donetion 5 Other (Specify) Goshen Cemetery 1/17/98 Gaithersbur 22. Name and Address of Facility											
any ir		21. Signiffure of Funeral Service Declare 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850											
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sician	8 1	23a. Part Enter the thease, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.										Onset and Deat	
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r: Aft	atio	1 Naturei 5 Panding invastigation	(Monin, Da)	rear)	Injury	М		Yes 2□No					
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To the Funeral Director: A completely filled in by the fu	edical	29a. Cartifier (Check only 2 Medical Exami	sicien: To the bast of	f my knowl	edge, daeth	occurred	at the tim	e, data and place	and due to the ca	use(s) and me	nner es st	eted.	
9 9	Med	Only .	and mannar sta	tad.	and of the								
들는		29b. Signature and titla of cartifiar				29	c. License	number	25	9d. Data signed	i (Month, L	Dey, Year)	
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To the		· CHOWE.	1001			1	اررر		OF	ANNHICA	15	1998	
Toth		30. Nama and address of person who co	omplated cause of de		23a) (Type, F		ارر	BOONSBOI			713	1998	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month Dev Veer **Physician** Henry John Hutchinson, Sr. 11 1998 4c. County of Deeth 4b. City, Town, or Location of Deeth /Medical 12:45AM 4a Fecility Nama (If not institution, give street and number) Examiner Annapolis Nursing and Rehabilitation Ctr. Annapolis Anne Arundel If Under 24 Hrs. Hours Min. 9. Birthplece (Stete or Foreign If Under 1 Year Months Deys 8. Date of Birth (Month, Dev. Year) 9. Birthplece (Ster County)
Sept. 15,1929 Mary Land 5. Sociel Security Number 6 Sev 7. Age (In yrs. lest birthday) **Funeral** M 2□ F 579-36-0862 68 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "naturel", or items 23e or 28e-f ehow the Medical Exprisher must be notified at 1 ☐ Yes 2 🔀 🏋 Director Maryland Anne Arundel Harwood 10e. Street end Number 10f Zip Code 10g. Citizan of Whet Country? 4745 A Flanders Lane 20776 U.S.A. Funerai 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1947 72 hours efter 1 ☐ Never Married 2 Married 1 XYes 2 No White 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 Specify Year or Dates: 1950 by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Int: If Item 27 is marked other than " Irry or other traumatic event, Ins Ma Elementery/Secondary (0-12) College (1-4or 5+) Floor Mechanic Walters Floor Service 8th N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles Hutchinson Nettie Windsor 2 19a. Informant's Nema/Ralationship (Type, Print)
Edna E. Hutchinson (Wife) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 4745 A Flanders Lane Harwood, Md 20776 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Jan. 13te 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If eny Injury or 1998 Ft. Lincoln Cemetery Brentwood, Maryland 4 ☐ Donetion 5 ☐ Othar (Spacify) Lee Funeral Home, Inc. 22. Name end Address of Fecility 21. Signature of Funerel Servica Licansee 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a. Pert1. Erder the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immadiata Causa (Final disease or condition resulting in daath) Examiner Examiner buriel-tran Sequentially list conditions, if eny, laading to immediate ceusa. Entar Underlying Ceuse (Diseese or Injury that initieled events rasulting in daath) Last Due to (or es e consequenca of): and certificate be execu Box 68760, physician Physician/Medical the Due to (or es e consequenca of): 88 eşn ō signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. P 24b. Were eutopsy findings eveileble prior to 24a. Wes an eutopsy Completed peen completion of cause of deeth? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 26. Place of Daeth (Chack only one) Be 25. Wes casa referred to medical exeminar? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? Certification: After 1 Netural 5 Pending daath. 1 Yes 2 No investigation 2 Accident or Attend after death Director: / 3 ☐ Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office bullding, etc. (Specify) in by 4 | Homicide To the Hospital c within 24 hours af To the Funerel Di completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Cartifian Medical 29b. Signature and title 29c. License number 29d. Date/signed/(Month, Day, Year)

complated causa of daeth (Item 23e) (Type, Print)

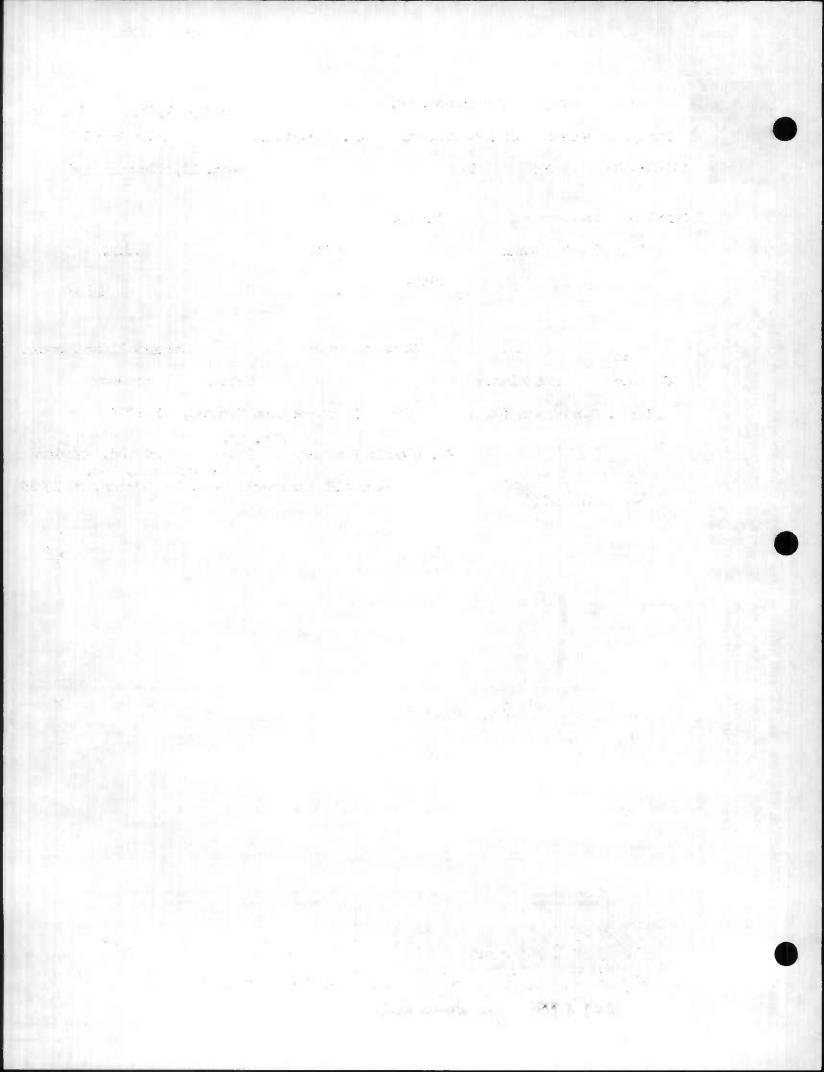
Signature

ers Signature

Abouter Raylett

State Registrar

JAN14



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month **Physician** 4 Hetlin Hen RY HARRISON On /Medical 4e. Fecility Name (If not institution, giva streat end numbar) 4b, City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Adeventist Hospital Washington Takoma Park Montgomery If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Yrs. Director 216-46-0731 91 March 3, 1906 Virginia Usuel Residence of Decedent with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "netural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 ☐ Yes 2 ₺ No Director Prince George's Chillum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 Cox Avenue 20783 USA Funeral 12. Was Dacedant Evar in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Raca - Amarican Indian, Bleck, Whita, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pemit. Pages 1 and 2 should be filed withir Department of Health and Mantal Hyglene Important: If item 27 is merked other than any Injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) Police Officer D.C. Police Department 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) William Carter Reflin Mary Elizabeth Dodd 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (wife) 833 Cox Avenue, Chillum, MD 20783 Jennie Vera Heflin 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 1/15/98 Brentwood, MD Francis J. Collins Funeral 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name end Address of Fecility Francis J. Collins I 21. Signeture of Funaral Servica Licansea Home, Inc. 23a. Part Enter the disease, or complications that caused the Beeth. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Silver Spring, MD 20901 Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel o cardia diseasa or condition resulting in death) Examiner Due to (or es e consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to Immadiate cause. Enter Undarlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Dua to (or es e consequance of) Physician/Medical Due to (or es a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by been sig 24b. Ware eutopsy findings eveilable prior to completion of causa of deeth? 24a. Was an eutopsy performed? Completed page 2 2 No certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, s 25. Was case referred to medical Be 26. Piece of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Nes 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28e. Deta of Injury (Month, Dey Yaar) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

22 defice Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

10

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

and

State Registrar

Medical

29e. Certifier

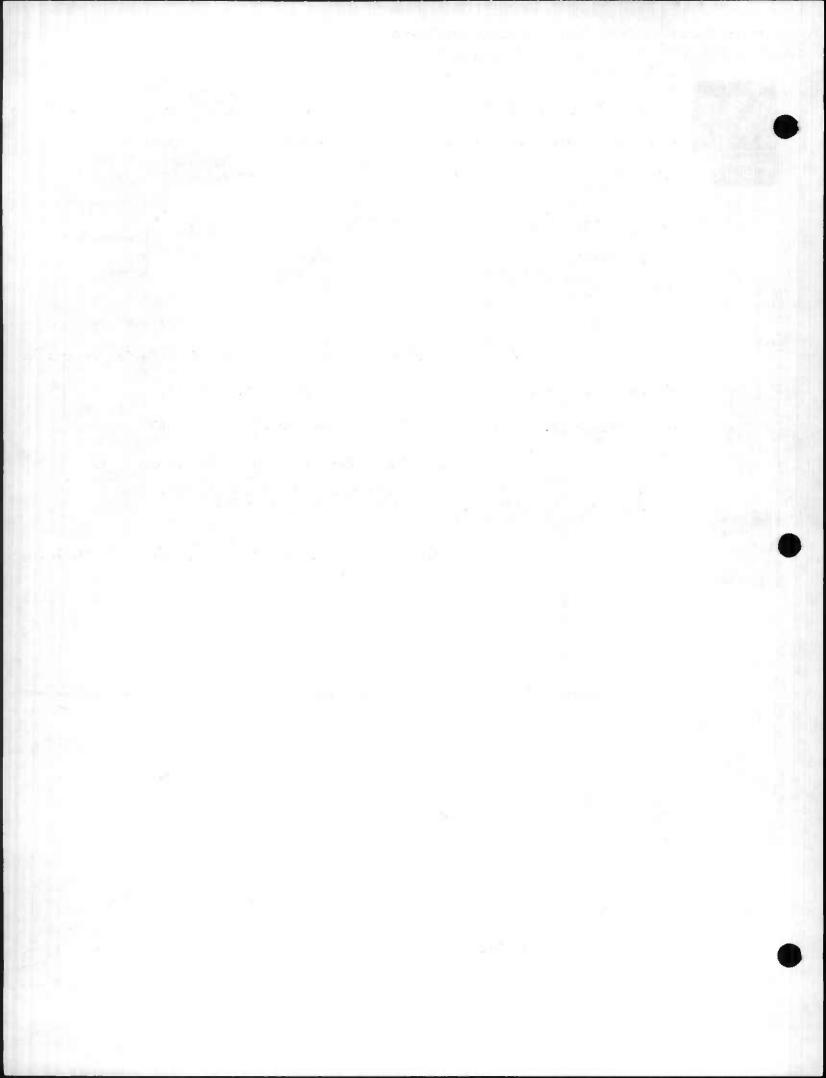
31. Date filed (Month

29b. Signetura and titla of cartifies

218 W. S Gargra ace bou 32 Registrar's Signature whia Davidson

Que

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month AN /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day), Year) | Jan-14, 1897 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 F 100 Maryland Yrs. Director 213-54-3203 Usual Rasidanca of Decedant tha Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumstic event, the Medical Examiner must be notitied at 1 Nas 2 No Director MD Howard Jessup 10a. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 23a or U.S.A. 20794 10480 Annapolis Junction Rd. daath Funeral **Items** 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Haelih and Mantel Hygiana. Important: If item 27 ie marked other than "natural". Any injury or other treumstic event. 1 ☐ Yas 2 【No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Married Black by 3 XWidowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) 7th Collage (1-4or 5+) Home-maker Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Laura Hebron George Matthews 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Bernice Wilson (Daughter) 10125 Guilford Rd., Jessup, MD 20794 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata Md. Nat'l Mem. Park 1/14/98 Laurel, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signalura of Funaral Sarvica Lie 22. Nama and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Entar the saasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or hear fullure. List only one cause on each line. Approximata Interval Between Onsat end Death Physician /Medical Immediate Causa (Final disaasa or condition rasulting in deeth) Examiner Examiner 11 The law requires that the death certificate be axecuted Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initieted evants physician and s the burial-trans Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 11 Physician/Medical thet initieted evants rasulting in daath) Last MONAR attending p for usa as ad by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of deeth? signad by t CARDIO VASIULAR LEROTIL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by should I 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performad? Completed paga 2 has 2 No 1 🗆 Yas 1 ☐ Yas 2 ☐ No cartificata or Attending Physician: diractor, 25. Was casa rafarred to medical axeminar? Be 26. Placa of Daath (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funaral 27. Manner of Death 1 U Natural 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. tnjury at Work? Aftar 5 Panding daath. 1 Yas 2 No Invastigation within 24 hours after death
To the Funeral Director: / 2 Accident 6 Could not be datarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homlcida Hospital Actifying Phyalcien: To the best of my knowledge, deeth occurred et the time, date and plece, end dua to the causa(s) and mannar es stated.

2. Mactical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Cartifiar (Check only one) To the 29b. Signatura and title of 29c. Licansa number 29d. Data signed (Month, Day, Year) 3

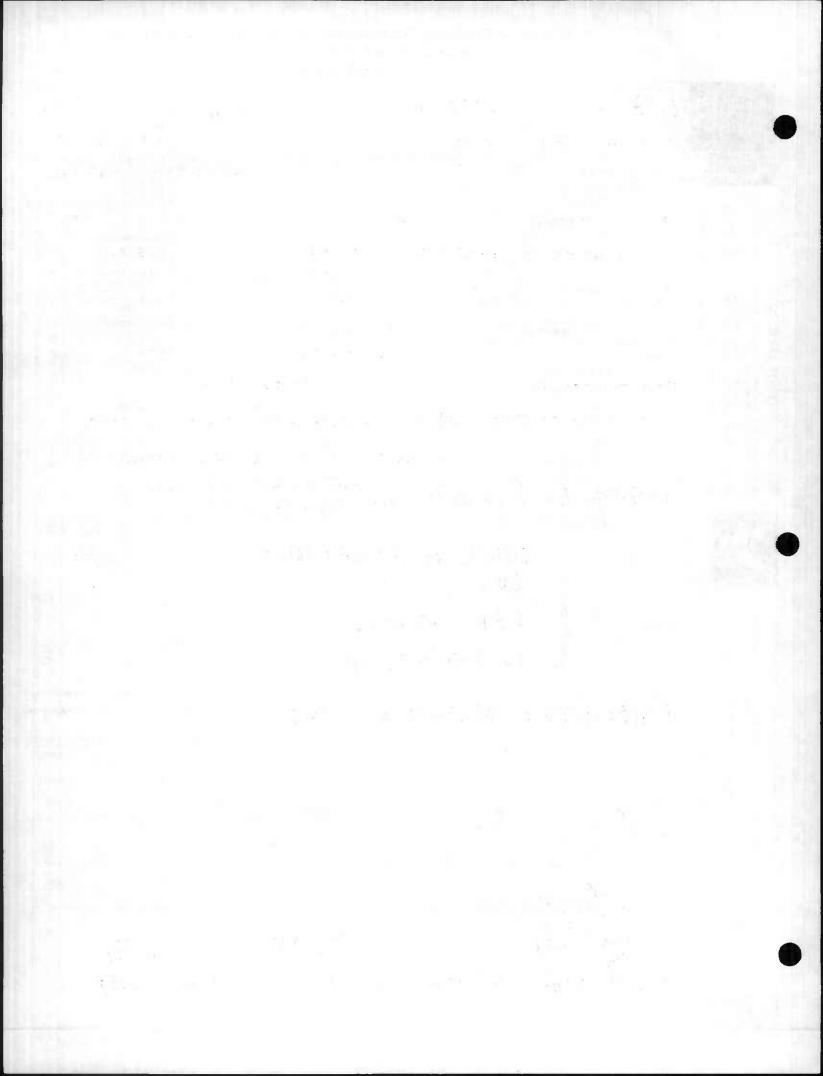
State Registrar

31. Dete filed (Month, Day, Year)

JAN 12 1998

30. Nama end address of person who complated cause of daath (Item 23e) (Type, Print)

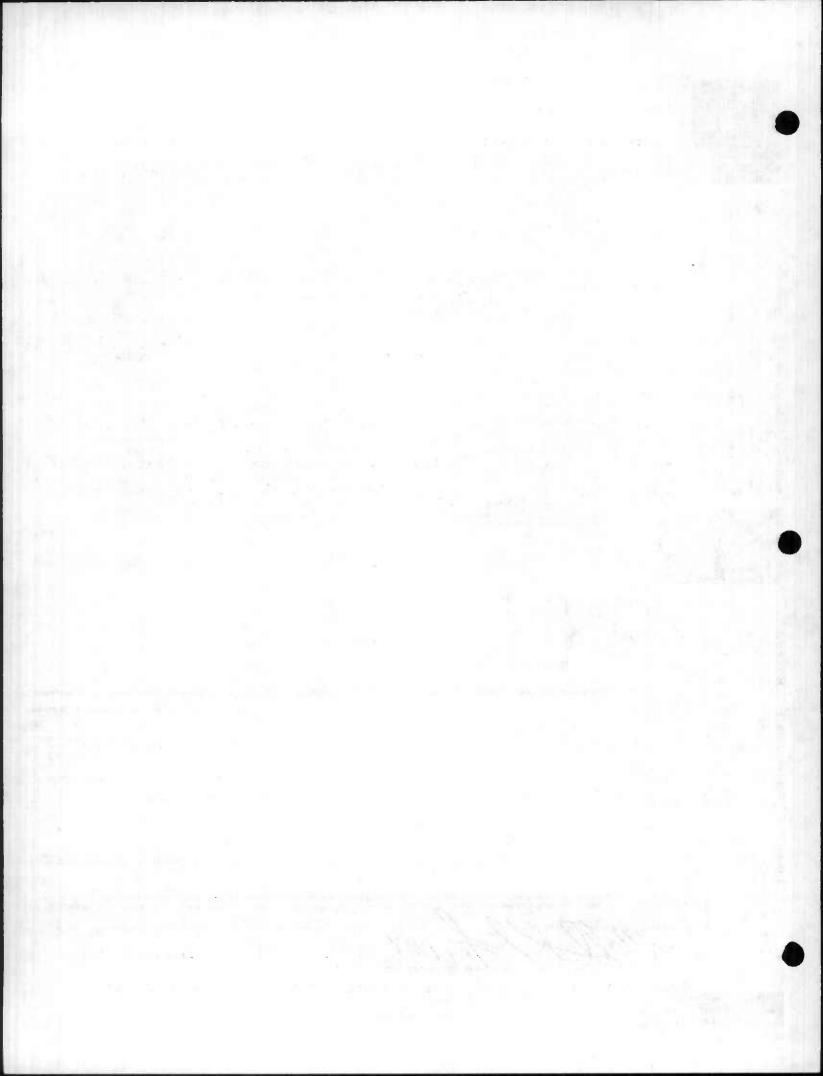
ESMACHADO 321 VEINCE GE GEORGE ST LAURER MID 32 Registrar's Signature usa Davidson-Randalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 12

					Certini	cate of	Death		Reg. No		
		1. Decedent's Nema (First, Middle,	Last)	Mari II	25111	F		2. Dete of De	eeth		3. Time of Dea
Physici /Medic		Ammon Walter H	oover					Month Januar	ov 13	Yeer 1998	11:28
Examin	_	4a. Facility Name (If not institution,	give straet and number)	10000		4b. City, Town, o	r Location of Dee	-	County of Deat	
		Collin swood Nu	rsing Cent	er			Rockvil	le le	M	fontgome	rv
Funeral			5. Sex 7. A	ga (In yrs. last		Indar 1 Year					hpiaca (Stata or For
Director		703-09-8175 Usuel Residence of Decedent	1X M 2□ F	75	Yrs.	mis Days	Hours Min	Feb. 1	8, 19	922 Penr	nsylvania
how how		10a. Steta 10b. County		10c. City, To	own or Location)					10d. Inside City Lin
r 28a-f ahow	Director	Maryland Montgo	mery	Rock	ville						1 ☐ Yas 2X
ith th)ire	10e. Street and Number			10	f. Zip Code			10g. Clti	izen of Whet Co	untry?
death with the Merylend ms 23a or 28a-f ahow	9	5706 Balsam Gro	ve Court			20852			Uni	ted Sta	ites
items items	Funerai	11. Marital Status	12. Was Decedent Armed Forces'	Ever in U,S.	13. Was E	acedent of h	lispanic Origin? (Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White	
a o	by Ft	1 ☐ Never Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 12 Yes 2 If Yes, Give Year or Dates:	Korean Confli	1 □Y	***	Specify:	nto riiozii, oto.,		Specify:	ite
"natural",	Pe	15. Decedent's	Education	16	Se. Decedent's	Usual Occup	ation		16b. Ki	ind of Business/	
hin 7	To Be Completed	(Specify only highast Elementary/Secondary (0-12)	College (1-4or	5.1)	(Give kind o	of work dona OT use retire	during most of w	orking	Inte	ernal &	Occupatio
- E L - E	E	Clotheritary/Secondary (0-12)	5+		Physic:	lan				Medic	
e filed al Hygie other vent,	3e C	17. Fether's Neme (First, Middle, La	st)				18. Mother's Na	ame (First, Middle	, Meiden	-	
12 should be to and Mental I is marked of iraumatic eve	0	Ammon B. Hoover					Katie	E. Harmo	n		
and A		19e. Informent's Name/Relationship		71 11 1	9b. Meiling Ad	dress (Street		Purel Route Numb		r Town, Steta, Z	(ip Code)
alth a		Elaine Hoover/W	ife		5706 Ba	alsam	Grove Co	urt, Roc	kvi1	le, Mar	yland 208
ges 1 and 2 should be filed to 6 Health and Mental Hyg If Item 27 is marked other or other traumatic event,		20a. Method of Disposition		20b. Plece	of Disposition	(Nema of	no)	Date		ocation - City or	
a c ti >		1 Burial 2 Cremetion 3 Donetion 5 Other (Spe		Monto	omery (Janu	ary 14, orium, I	1998	Rot	honda	Maryland
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Depa Impo any i		NavalE	· Cerry	. моово	Rocky	ville.	Inc. 3 Marylan	00 West	Mont	gomery	Avenue
Physiclan /Medical Examiner	er	Immediate Ceuse (Final disaase or condition resulting in deeth)			e consequence	of):					
nsit	듵		b. Mult:	iple St						i	
e execucian and surfal-tra	i Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury		Dua to (or as	e consequence	of):					
	0	thet initieted events resulting in deeth) Lest		Dua to (or es	e consequence	of):					
death ce e attendi ed for use			d								
0 0 -	Sic	Dort II Other elevidians and distant	contributing to death h	out not resulting							
bed of		Pert II. Other significant conditions	continuating to death b	or mor reconning	In the underly	Ing causa giv	en in Pert I.	23b. Did	tobacco	use contribute	to the cause of dea
y the	y Physician	Pert II. Other significant conditions	contributing to death to		In the underly	Ing causa giv	en in Pert 1.				
5.6	by	Pert II. Other significant conditions	out out ing to deal it		in the underly	Ing causa giv	en in Pert I.	1 □	Yes 2	No 3 Pr	obably 41 Unkn
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ete hes been sign page 2 should be	Completed by	25. Wes cese referred to medical	Contributing to death of		g in the underly	ing causa giv		1 🗆 24e. Was perfo	Yes 2	No 3 Pr	completion of cause
is certificate has been sign director, page 2 should be	Be Completed by		Hospital: 1 Inpatia		n the underly Dutpetient 3C	Oth	26. Place of De	24e. Was perfo	Yes 2 en eutopormed? Yes 2	□ No 3 □ Pr	Were eutopsy finding variable prior to completion of cause of deeth?
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	1	g. No.	01914
Physic		1. Decedent's Name (First, Middle, Last) ELLA HELEN HAYNES	JANUARY	_	3. Time of Death 4:45 PM
/Medi Examii		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or to the control of the contro	ocation of Deeth	4c. County of	Deeth
Funeral Director	B	2104 FLORAL PARK ROAD 5. Social Security Number 220-44-6896 6. Sex 1 M 2 F P P P P P P P P P P P P P P P P P P	8. Date of Birth (Month, Day, APRIL 4,		GEORGE'S Birthplece (State or Foreign MARYLAND
the Maryland 28a-f show notified at	tor	Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location MARYLAND PRINCE GEORGE'S CLINTON			10d. tnside City Llmits 1 ☐ Yes 2 🔭 No
th with	Funeral Director	10e. Street end Number 2104 FLORAL PARK ROAD 10f. Zip Code 20735	10	g. Citizen of Whe	
or Ite	by	11. Maritel Status 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, specify Cuben, Mexicen, Puerto Year or Dates: 13. Wes Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexicen, Puerto Year or Dates:	pecify Yes or No- o Rican, etc.)	Black,	Americen Indien, White, etc.
VIVIDA 1 within 72 Jiene. Ir than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupetion (Give kind of work done during most of wor life. DO NOT use retired) CLERK ACCOUNTANT	king	6b. Kind of Busin	
ite; Maryiana 2 s 1 and 2 should be filed if Health end Mental Hygic Hem 27 Is marked other other traumatic event, it	To Be C	17. Fether's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, M LIZZIE SP	a <i>lden Sum</i> eme)	
other traum		19a. Informent's Name/Relationship (Type, Print) JACQUELINE M. HUFFMAN/DAUGHTER 19b. Melling Address (Street and Number or Ru 8809 CANBERRA DRIVE,			
00		20a. Method of Disposition 1	AN.20, 19		y or Town, State INGTON, VA
permit. Page Department. Important: if any lojury or		21. Signature of Funeral Service Licensee ARK G. BROHAWN MO0053 22. Name and Address of Fecility THE HUNTT FUNERAL PO. BOX 156, WALD	ORF, MARY	LAND 2	0604
Physician /Medical Examiner	1000		Dîse		Approximete Intervel Between Onset end Deeth
bath certificate be executed attending physician end for use es the buriel-transit	in/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):	MÍA		7/4R
signed by the ettending be deteched for use	Physician/N	Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. CEREBROVASCUAR DISEASE			bute to the cause of death?
been should	Completed by		24e. Wes en	eutopsy ed?	24b. Were sutopsy findings eveilable prior to completion of cause of deeth?
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Attanding Physician: The lev robath. crot. After this certificate has by the funeral director, page 2	ıtlon: To Be	25. Was cese referred to medical exeminer? Yes 2 No	ome 5 Resider 28d. Describe how	ice 6 Other	(Specify)
	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,		or Rural Route Number,
To the Hoapital or within 24 hours effe to the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece 2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on meaning the second examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on the second examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on the second examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on the second examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on the second examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece on the second examinetion end/or investigation, in my opinion, deeth occurred et the time, determined examinetion end/or investigation, in my opinion, deeth occurred et the time, determined examinetion end/or investigation, in my opinion, deeth occurred et the time, determined examinetion end/or investigation, in my opinion, deeth occurred et the time, determined examinetion end/or investigation, in my opinion, deeth occurred et the time, determined examinetion end/or investigation, in my opinion examined examinetion end/or investigation.	, end due to the cer rred et the time, dat	use(s) end menno te end place, end	er es steted. I due to the ceuse(s)
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		20 Name and address of person who completed cause of death (New 23e) (Type, Print) DICAMTAN 913 VICATAWAM	20 CL	INTO	on mo
Sta * Registr		31. Dete filed (Month, Day, Year) 32. Registrer's Signeture			

Av I C AND SOLD A REST HE WAS A SHOOT HERE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #8, 1/20/98, BMW, Montg. Co. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Timu of the Month **Physician** MARGARET ETHEL HOUSE 11, 1998 6:50PM Jan. /Medical 4a. Facility Name (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care-Chevy Chase Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 257 F Yrs Director 89 1990 Washington, DC 578-44-2372 Usual Rasidance of Decedani 26, 1908 the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits rai", or items 23a or 28a-f shov Examiner must be notified at 1 Yas 2 □ No Director MD Montgomery Bethesda 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 5913 Carlton Lane 20816 U.S.A Funerai death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amaricen Indian, Bleck, Whita, alc. filed within 72 hours after I ☐ Yas 2 ▼ No If Yas, Giva Yeer or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No þ Specify: White 3 Widowad 4 Divorced "natural", Completed The Medical 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elemantary/Sacondary (0-12) Collega (1-4or 5+) 9 Own Home Homemaker other permit. Peges 1 and 2 should be file Depertment of Health and Mantal Hy, Important: If Item 27 is merked othe any Injury or other treumatic event 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Be Ethel Mountcastle Lo John Grover Osborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Hobart Roosevelt House-Husband 5913 Carlton Lane, Bethesda, MD 20816 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 X Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) 1/15/98 Washington, DC Rock Creek Cemetery 21. Signatura of Funaral Sarvice Licensas Joseph Gawler's Sons INC frey Freil 5130 Wisconsin Ave. NW Washington, DC 20016 Part Penter the disease, or complications thet ceusad the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwean Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 1 day Aspiration Pneumonia Examiner Due to (or as a consequance of): Examiner Cerebral Vascular Disease 15 Years The law requires that the death certificate be executed **bunal-transi** Sequantially list conditions, if any, laading to Immadiata cause. Enter Underlying Ceuse (Disaasa or Injury thet Initiated avants rasulting in daath) Last Due to (or as a consequence of) Box 68760. physician Physician/Medicai the Dua to (or as a consequence of) 8 for use Part II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Senile Dementia, Hypothyroidism Division of Vital Records, þ 8 24b. Ware eutopsy findings availabla prior to complation of ceusa of daath? 24a. Was an autopsy performad? Completed has paga 2 1 Yas 2 No cartificata 1 ☐ Yas 2 ☐ No funeral diractor. Be 25. Wes casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mennar of Death 28a. Dete of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? 5 ☐ Panding invastigation or Attanding 1 X Neturel 24 hours after death. 1 Yas 2 No 2 Accident the 6 Could not ba 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) in by 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida Hospitai 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end mennar es steled.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner staled. 29a. Certifian Medicai completaly

29c. Licansa number

DO 1948

8218 WISCONSIN AVENUE, BEHTESDA, MD 20814

29d. Data signad (Month, Day, Yaar)

1/14/98

State Registrar 29b. Signature and fille of certifie

BLAINE FITZGERALD

37. Date filed (Month, Day, Year) 32. Registrar's Signature 5 rolla Dividon

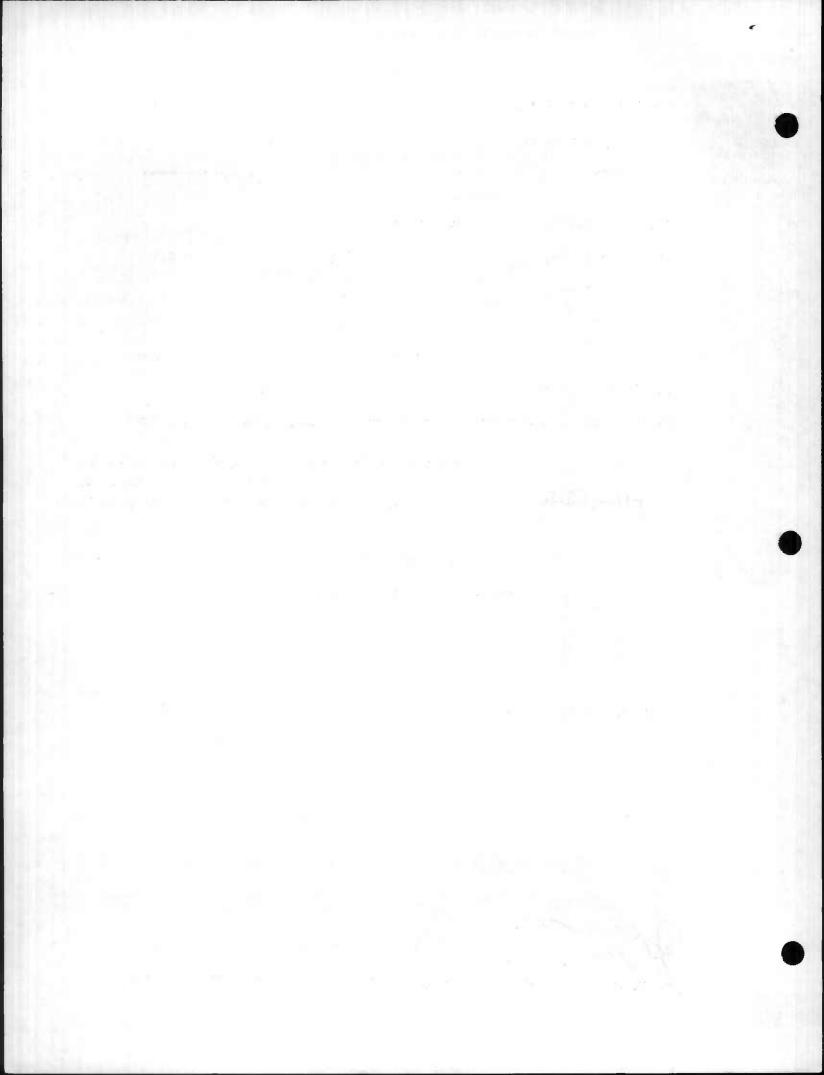
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Yaar 1.45 m Allen Holderman Eugene 4b. City, Town, or Location of Deeth ક 1998 4e. Fecility Name (If not institution, give straat and number) 4c. County of Death Genisis Elder Care La Plata Charles | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | Feb. 18, 1934 | Tillinois 5. Social Security Number 7. Aga (In yrs. lest birthday) 1 M 2 □ F Yrs. 350-28-6246 63 Usuel Rasidence of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Charles Maryland La Plata 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? One Magnolia Drive 20646 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Bieck, White, etc. 1 Tyes 2 Nd 956 If Yes, Give Yaar or Detes: 1958 1 Never Merried 2 Married 1□ Yes 2√ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Office Worker Retail 17. Fethar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surname) Wilbur C. Holderman Holderman Ruth Moher 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Numbar or Rural Route Number, City or Town, State, Zip Code) Richard A. Holderman/brother 914 Lawton St. McLean, VA 22101 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burial 2XX remation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/10 Alexandria, VA 21. Signeture of Funerei Servica Licensea 22. Name and Address of Fecility M00817 Arehart-Echols Funeral Home, P.O. Box 567 La Plata, MD 20646 23e. Pert1. Enter the diseasa, or complications that causad the death. Do not enter the moda of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only ona cause on aach line. Immediete Cause (Finel diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disaesa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably Unknown 24a. Was an autopsy performed? 24b. Ware autopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yas

Physician /Medical Examiner

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/Medical

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Manylan nent of Health and Mantal Hygiane. Int: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show

Baltimore, Maryland 21215-0020

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiane. Important: if from 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinations and permitted at process.

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Examiner burial-transit attending physician for use as the budge Physician/Medical ed by the at detached for ate has been signed by paga 2 should be detac Completed by cartificate Be 2 this Iuneral Certification: Aftar death. within 24 hours after death To the Funeral Director: completely filled in by the

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or Attending Physician: The law requires that tha death certificata be executed

Hospital

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Division of Vital Records, P.O. Box 68760.

Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I.

1 ☐ Yas 2 ☐ No

25. Wes casa referred to medical 26. Pleca of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetiant 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Marher of Deeth Waturel

5 Pending Invastigation 6 Could not be datamined Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

28e. Dete of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 1 Yes 2 No 28d. Dascribe how Injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

Cartifying Physician: To the best of my knowledga, daeth occurred at the time, dete end place, and due to the cause(s) and mannar as stated.

Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha tima, date end place, end due to the cause(s) end mannar stated.

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

30. No

31. Dete filad (Month, Dey, Yeer)

JAN 1 2 32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Items: 28a.d-f per ME G-756 2/10/98 dh 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day Joseph R. Houser January 8, 1998 1:00 AM 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1월M 2□ F 178-14-3666 77 30, 1920 Pennsylvania Usuai Residance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2 No Maryland Rockville Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 1004 Gilbert Road 20851 United States 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 1⊠ No If Yes, Give Year or Datas: Was Dacedant of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 1 ☐ Navar Married 2 ☐ Merried 1 Yas 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Machinist Manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumema) Joseph Clarence Houser Maude Swan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 7622 Huntmaster Lane, McLean, Joseph R. Houser, Jr./Son Virginia 22102 20b. Place of Disposition (Name of cematary, crematory or other place) Jan. 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1998 Montgomery Crematorium, 4 ☐ Donation 5 ☐ Othar (Specify) Inc. Bethesda, Maryland 22 Nema end Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00198 a sasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest must failure. List only one ceuse on each line. Approximete Intarvel Between Onsat and Death Immediate Cause (Final disaasa or condition rasulting in daath) a. CAR DIO MYO PAT Dua to (or as a consequence of) INDEF Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Lest Dua to (or as a consequence of): Dua to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 5 Unknown FRACTURED 24a. Was an eutopsy performed? 24b. Wara autopsy findings eveileble prior to complation of ceusa

Hospital or Attending Physician: The law requires that the death certificate be executed Sty burs after death.
 Funneral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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items 23s

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23.

Department of Health are important: If item 27 is any injury or other trau

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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axaminar? Yas 2□ No	Hospitai:	ER/Outpatient 3	DOA Ott	er: 4 Nursing	Homa 5 ☐ Rasidance 6 ☐ Otha	r (Specify)
27. Mannar of Death 1 Natural 5 Pendir invasti	28a. Data of Injury (Month, Day Year) gation 28a. Data of Injury (Month, Day Year) dec. 20	28b. Tima of injury M	28c. Inju Wo 1 🗆	y at k? Yas 2,0 No	28d. Dascribe how injury occurred fell in School	1 ₁ parking lot
3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida datarm	28e. Place of Injury - At hor building, atc. (Specify, school parking))	_		28f. Location (Straat and Number City or Town, Stata) School	er or Rural Route Number
29a. Certifiar 1 Certifyir	ng Phyelcian: To the best of my know	vladga, daath occurr	ed at the ti	na, data and plac	e, and dua to the cause(s) and man	nner as stated.

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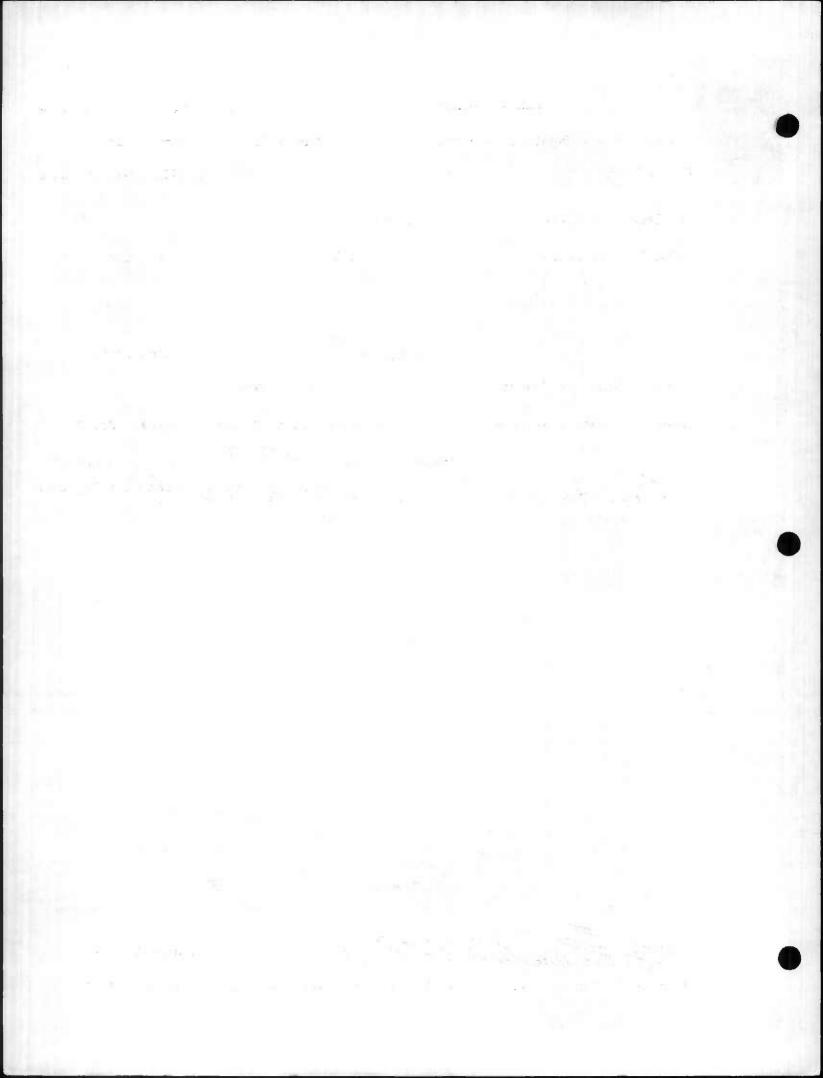
January 9, 1998

d/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar steted. 29b. Signature and title of cellular 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Fint)

Francis C. Mayle, Jr., M.D. 10215 Fernwood Road, Bethesda, Maryland

State Registrar 31. Data filed (Month, Day, Year) JAN 12 1998 32. Ragistrar's Signature Wia Davidson-Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month VE POYCE JANUARY 2, 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year if Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 6. Date of Birth (Month, Dey, Yeer) Oct. 4, 1919 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country)
 VA M 2 F 578-22-6514 78 Yrs. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6213 12th Street, N. W. 20011 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. No Yes 2 No If Yes, Give 44. Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify **Black** Specify: 3√ Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Window Washer Private Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Arthur Jackson Viola Kemp 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Levier Hunt - Niece 6213 12th Street, N.W., Wash., DC 20011 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Surial 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) Quantico National Cem. 1/8/98 Triangle, VA 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility R. N. Horton Co. Morticians, Inc. Mark 1 37 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finet disease or condition resulting in deeth) Caneer with bone Medstass Due to (or es e consequence of): la lay trition Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): PARCHONIA Horration Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

The lew requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records.

or Attending Physician:

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Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

Director

Funeral

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Physician/Medicai 950 signed by the atte by Completed Be Certification: To the To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by the

Medical

State Registrar

25. Wes cese referred to medicel exeminer?

Hospitel: 1 Monpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel

5 Pending Investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

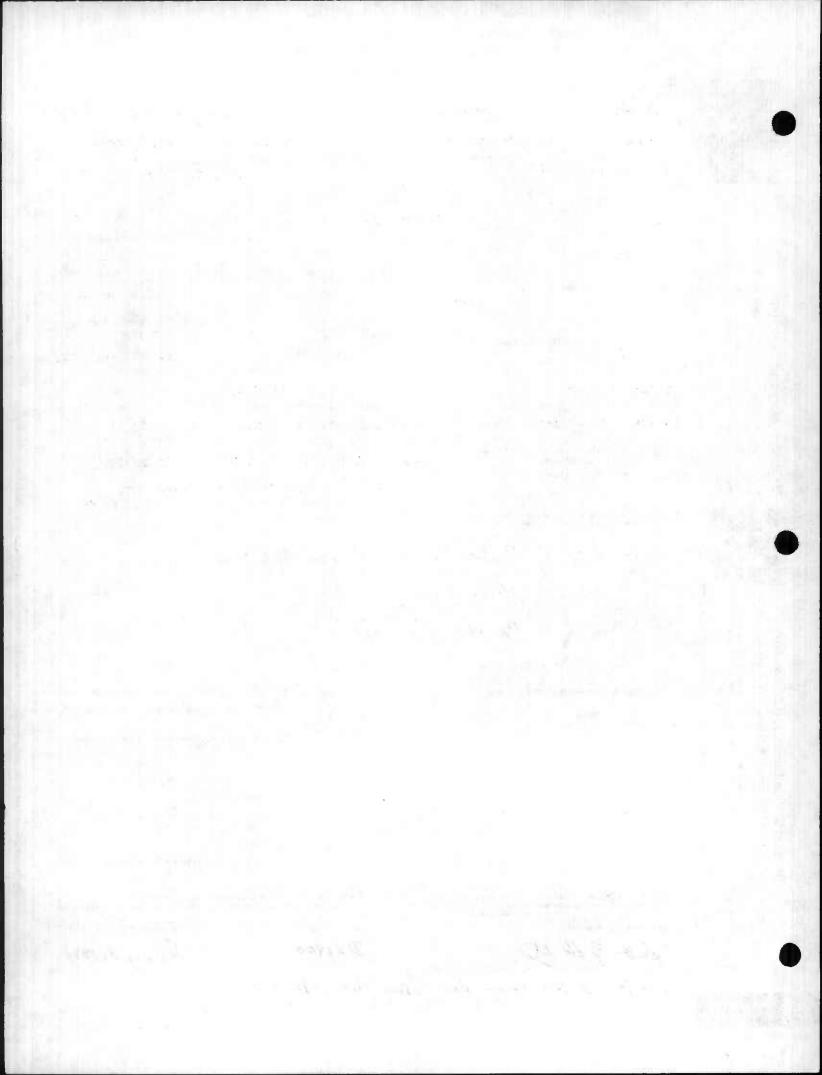
| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steted. 29a. Certifier (Check only one)

29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

CARRIL Bue 1/4 Koma

32. Abgistrer's Signature Randesse M.D 1910



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Jozef Kedziora 11, 1998 5:30 January MA 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Springbrook Adventist Nursing & Rehab. Silver Spring Montgomery 7. Age (In yrs. last birthday) if Under 1 Year Months Days If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□ F Yrs 74 Jan. 17, 1923 216-38-6665 Poland Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 12325 New Hampshire Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 1956--76 1 ™ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry United States College (1-4or 5+) Elementery/Secondary (0-12) 12 Soldier Army 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 D Street, N.W., Washington, DC 20001 Lawrence M. Spillan (guardian) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 1/20/98 Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funerel Service Licensee 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 23e. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, a heart failure. List only one cause on each line. Approximete Interval Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) UMONIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at

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Baltimore, Maryland 21215-0020

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The law requires that the death certificate be execu signed by the a Attending Physician: After this Mospital or Attending 24 hours after death.
 Funeral Director: After death filled in by the fur pletely To the Within 2 To the

Division of Vital Records. P.O. Box 68760.

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				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 No	1 ☐ Yes 2 No
25. Wes case referred to medical			26. Plece of De	eeth (Check only one)	
examiner?	Hospital: 1 ☐ inpatient 2 ☐ ER	NOutpatient 3□ DO	A Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Death 1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	8b. Time of Injury M	Bc. Injury at Work?	28d. Describe how injury occur	
3 Suicide 6 Could not be determined		e, farm, street, factory,	office	28f. Location (Street end Numb City or Town, Stete)	per or Rural Route Number,

29a. Certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

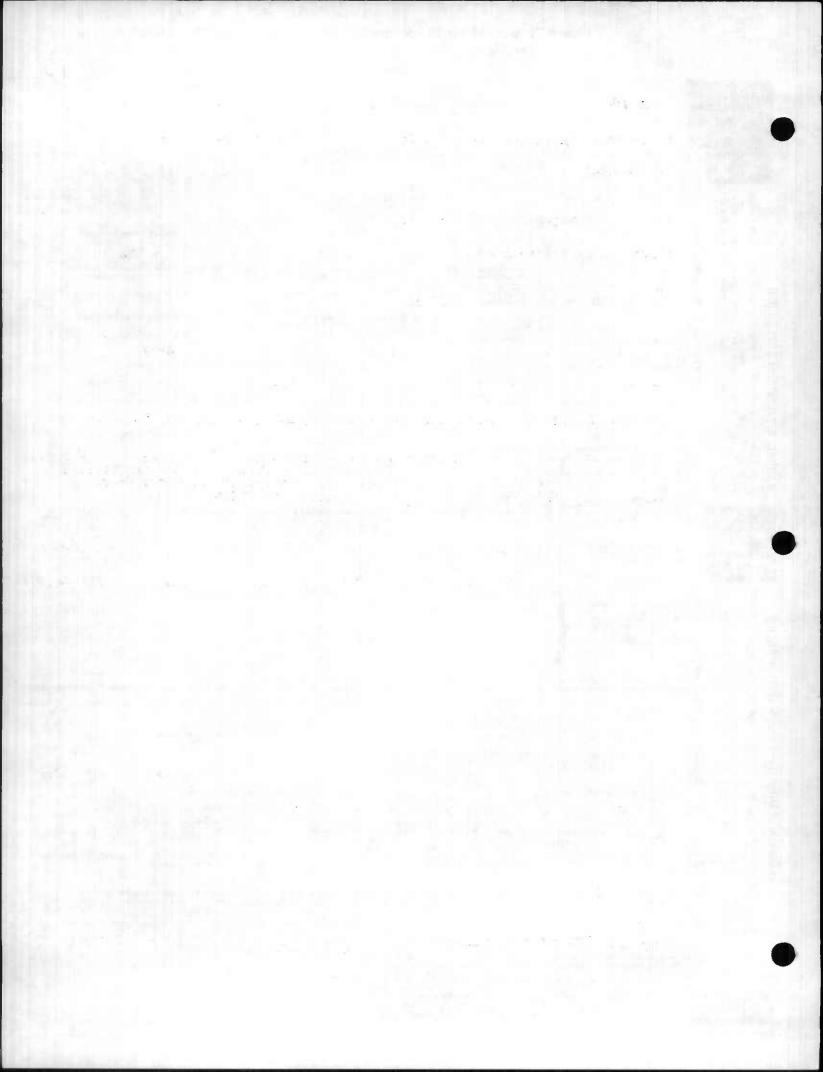
Paul Armstrong 14201 Laurel OK Dr. 102 Laurel mo 20707 31. Date filed (Month Day Year)

State Registrar

Medical



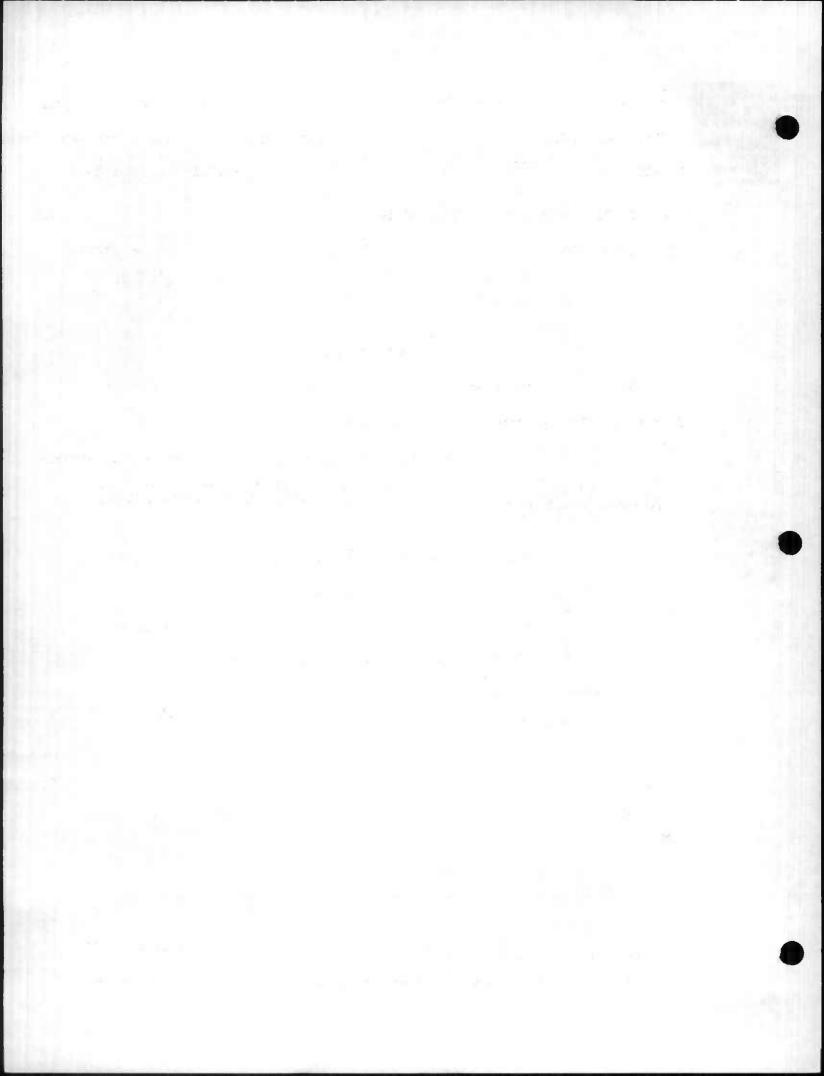
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State of Maryland / Department of Health and Mental Hygiene 9 8 1 9 2 1

		Decedent's Name (First, Middle, Las	t)		06/1	tificate of	Death	2. Date of Deat	eg. No.		3. Time of Death
Physic /Medi		Elizabeth J.		urne				January 1		3 Year	9:10A.
Exami		4a. Facility Neme (If not institution, give 4704 Sellman Roa	The state of the s)			4b. City, Town, or L Beltsvil		4c. County		orge's
Funeral Director		212-10-4400	9X □ M XXF 7. A	ge (In yrs. last 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Pay. Dec. 7, 1	908	9. Birthpl Mary	ace (State or Foreig Yand
Manyland -f show	tor	Usual Residence of Decedent 10e. Stete 10b. County Maryland Prince G	eorge's	10c. City, T	own or Loc SVill					10	0d. fnside City Llmits
th with the 23a or 28a	ai Direc	10e. Street and Number 4704 Sellman Road				10f. Zip Code 20705		1	0g. Citizen of V Unit	What Count	
72 hours efter death with the Maryland "natural", or frems 23a or 28a-f show ofcal Examinat must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married XXWidowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 20 If Yes, Give Year or Dates:	?		as Decedent of New Yes, specify Cub	dispanto Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - America ck, White, e	
S 3	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or			ent's Usual Occup ind of work done O NOT use retire C Cutte	pation during most of work d)	king	16b. Kind of B	usiness/Ind	ustry
d 2 should be filed within the end Mentai Hygiene. 7 is merked other then treumatic event, the Mentain treumatic event, the Mentain the Me	To Be C	17. Father's Name (First, Middle, Last) Nicholas	Woynovi	ltz			18. Mother's Nam Anna	e (First, Middle, M		hmidt	
end 2 should saith end Men n 27 is marka er traumatic		19a. Informant's Neme/Relationship (7 George J. Kilbour				Address (Street	and Number or Ru	ral Route Number	City or Town,	State, Zip	Code)
permit. Pages 1 end Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition XX Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		e of Dispos etery, crem-	ition (Name of etory or other ple			20c. Location		wn, State Maryland
permit. Peg Department Important: It any Injury o		21. Signature of Funeral Service Licens		A	DO	Name and Addre	ess of Fecility Borgward er Mill Ro	t Funera	1 Home	P.A.	
eath certificate be executed ettending physician and for use as the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last	o. Athle	Due to (or as	a conseque	mod of): Per	sease ferial V	souls.	-Dis	iasi	
The law requires that the death certificete be executed ate has been signed by the ettending physician end page 2 should be detached for use as the buriel-transit	ed by Physician/N	Part II. Other significent conditions co	ntributing to death t	out not resultin	g in the und			23b. Did to	n eutopsy	3 ☐ Prob	re autopsy findings
ician: The law recentificete has bee	Completed	allengton A	+					perform		of o	pilable prior to appletion of ceuse deeth?
an: T	BeC	25. Was cese referred to medical	2016				28. Piece of Dee	th (Check only on	1111		Yes 2 XX
nysici iis ce i direc	To	exeminer? 1 ☐ Yes 200 No	Hospital: 1 Inpeti	ent 2 ER	/Outpatient	3□ DOA Oti	ner: 4 Nursing H	ome 5 XX eside	ence 6 🗆 Oth	er (Specify	')
To the Hospital or Attanding Physician: The li within 24 hours effer death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Certification:	27. Nanner of Death Sample of Death 28a. Dete of Injury 28b. Time of Injury 28b.						28d. Describe ho	ow injury occur	red	
ital or Att its after d al Diract led in by	Certifi	3 ☐ Suicide 6 ☐ Could not be determined	building, el	tc. (Specify)		et, factory, office		28f. Location (St City or Town	n, State)		
in 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sicien: To the best fner: On the basis o and manner st	n examination	dge, death end/or inve	occurred at the ti estigation, in my o	me, date and place, opinion, death occur	and due to the cared et the time, d	ause(s) and mete and plece,	enner es st end due to	eted. the ceuse(s)
Tot	W	29b. Signature and title of certifier	Mlan	nay I	D	29c. Licens	15347		9d. Date signe January		
-		30. Name and address of person who c	ompleted cause of	dooth /Itam 22	CT . F						



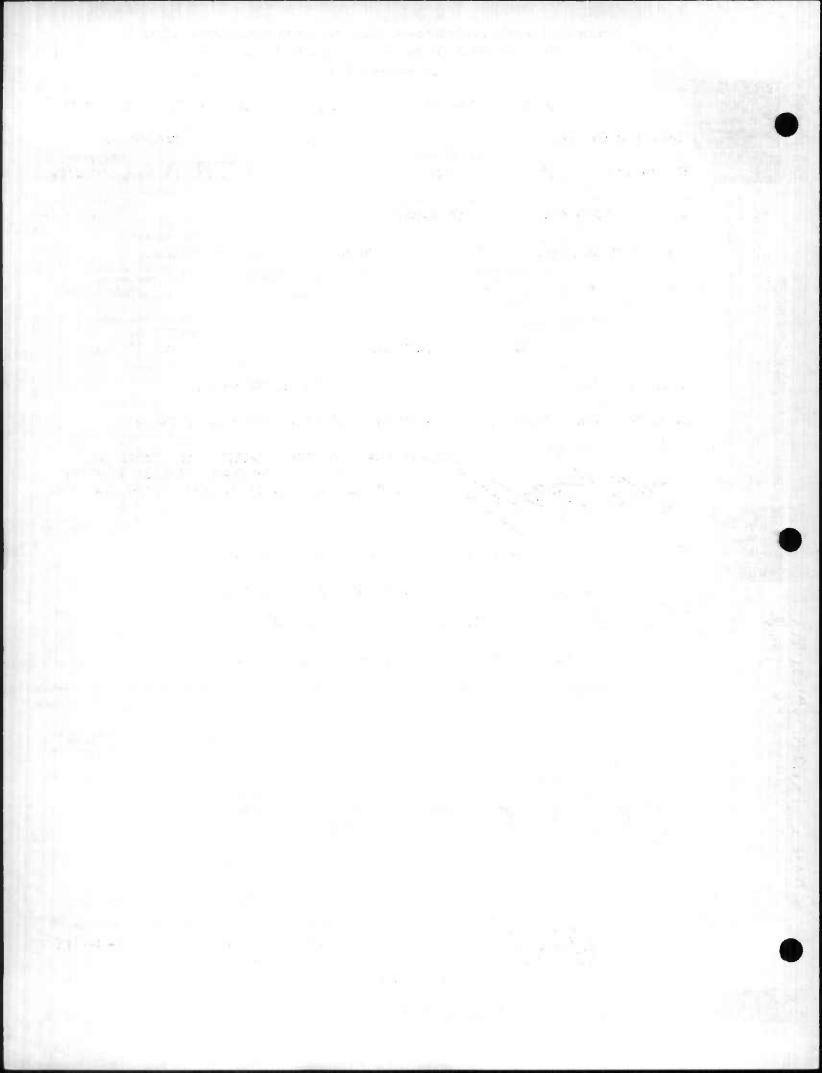
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 6:15 PM JANUARY JAMES **EDWARD** KIRK 8, 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** SUBBURBAN HOSPITAL **BETHESDA** MONTGOMERY 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign **Funeral** 1 X M 2 □ F Months Deys Hours 185 14 6592 Yrs Director 82 NOV. 23, 1915 MASSACHUSETTS Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryla Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Examinat must be notited at once. MD MONTGOMERY BETHESDA 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7910 KENTBURY DRIVE 20814 U.S.A. Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 No If Yes, Give Year or Dates: Was Dacadent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: CAUCASIAN 1□ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BUREAU OF Elementary/Sacondery (0-12) College (1-4or 5+) ENGINEER PUBLIC ROADS 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be EDWARD M. KIRK CATHERINE WHELAN P 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Numbar, City or Town, Steta, Zip Code) G. ISABEL KIRK - SPOUSE 7910 KENTBURY DR., BETHESDA, MD 20814 20a. Method of Disposition
1 ABurial 2 □ Cremetion 3 □ Ramovel from Stete 20b. Pleca of Disposition (Name of cemetary, crematory or other plece) 20c. Location - City or Town, Stete JUNIATA MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) 1/12/98 LEWISTOWN, PA 21. Signature of Fungral Septo Licenses 22. Name and Address of Fecility AFFORDABLE FUNERAL SERVICES 2230 GALLOWS RD., #110, DUNN LORING, VA 22027 Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiec or respiretory arrast, shock, or heart failure. List only one cause of shock line. Approximate Intervel Batween Onsat and Death Physician Immedieta Cause (Finel disaese or condition resulting in deeth) /Medical AWTE MYOCARDIAL INPARCTION Examiner Due to (or es e consequenca of): Examine PULMONORY BUEMA AUTE for use as the bunal-tran Sequentially list conditions, if eny, laading to immediata cause. Enter Undarlying Ceuse (Diseesa or injury that initietad evants rasulting in death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760. MAPIRATION PNEUMONIA Physician/Medical Due to (or as a consequenca of): 2FNKERS DIMPRILWWA Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Tes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes en eutopsy completion of cause of deeth? certificata has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminar? 26. Place of Deeth (Check only one) P Othar: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Menner of Death 28c. Injury et Work? Certification: 28d. Describe how injury occurred 5 Pending Investigation Naturel r daath. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours effer of To the Funeral Direct 4 \ Homiclda edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to tha ceusa(s) end mennar es statad.

2 Medical Examínar: On the basis of axamination and/or investigetion, in my opinion, daeth occurred et tha tima, data and placa, and due to tha ceuse(s) end mennar stated. complataly (Check only one) 29b. Signeture end titla of certifile 29c. License number 29d. Dete signed (Month, Dey, Year) D 27427 mo) 30. Nema end addrass of p declaration (Item 23e) (Type, Print) BETHESDA, MN 20814 OUD GRORGBROWN 120. BAKSHI n.O 9406 32. Registrer's Signeture 31. Dete filed (Month, Day, Yeer) State Registrar

DHMH 16 Rev 6/95

JAN-811928



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 10:20 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth General If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 11X M 2 F 76 May 30, New Jersey 136-18-8156 10b. County 10c. City. Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2806 Clear Shot Drive # 3 20906 TISA 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 250 Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Furniture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Max Kivitz Yetta Goldberg 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2806 Clear Shot Dr. #3 Silver Spring, MD 20906 ca of Disposition (Neme of Date 20c. Location - City or Town, State Dorothy Kivitz-spouse 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Judean Memorial Gar, 1/15/98 Olney, MD 21. Signeture of Funeral Sery 22. Name end Address of Fecility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD20852 Approximate Intervel Between Onset end Deeth -Edward Sagel on plicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest by age cause on each line. and. Enter the disease, or com-shock, or heart failure. List only Immediete Ceuse (Finel diseese or condition resulting In deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown rebut la tron 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? rala Disere fevere 24e. Wes en eutopsy performed? Mema 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one)

Physician /Medical Examiner

sician and burial-transit

physician s tha burial

P.O. Box 68760.

Records,

Division of Vital

Physician

/Medical

Examiner

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Director

Funeral

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Completed

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MD

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within Department of Haalth and Mantal Hygiana. Important: If them 27 Is marked other than ony Injury or other transmissions.

tha Maryland

Physiclan/Medical by Completed Certification:

signed by t has cartificata To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartific completally filled in by the funaral director, Medical

Registrar

1 Yes 2 No 27. Manger of Deeth 1 Natural 2 Accident 3 ☐ Sulcide 4 ☐ Homicide

29a. Certifier

2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated.

28e. Dete of Injury (Month, Day Yeer) 5 Pending Investigation 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted.

29b. Signeture end title of certifier

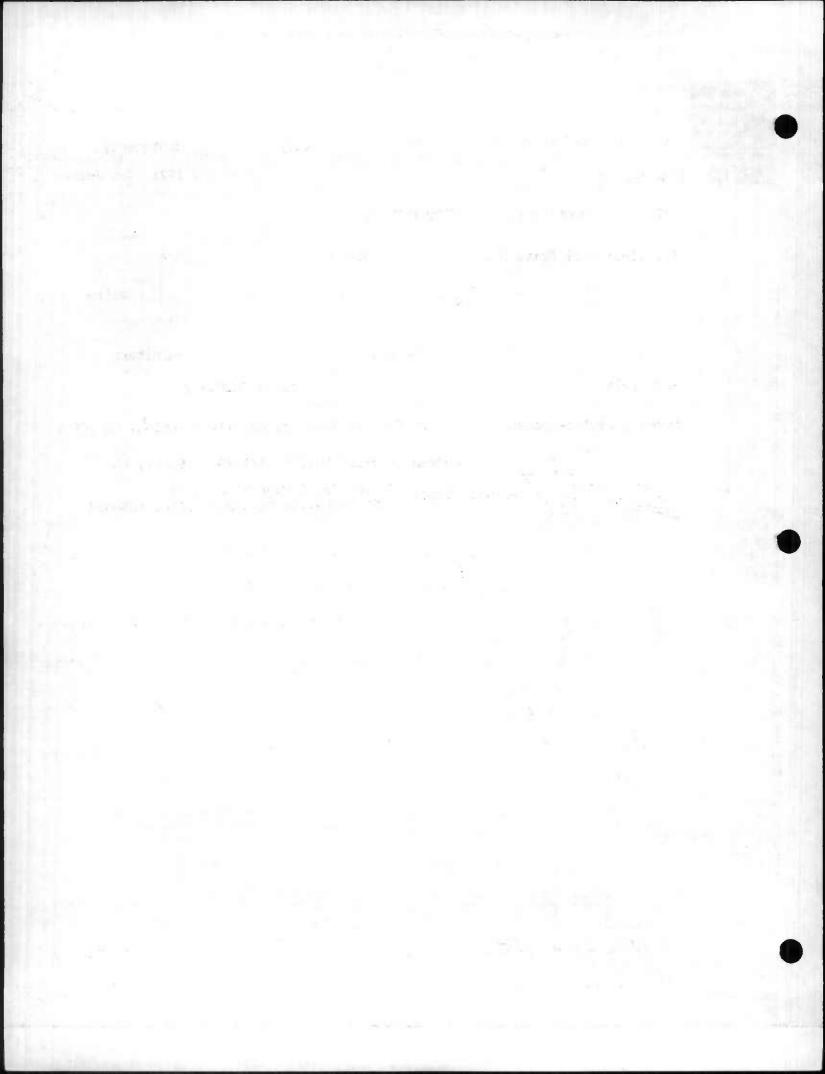
29c. License number

29d. Dete signed (Month, Dey, Yeer)

30. Neme end eddress of berson who completed cause of deeth (Item 23e) (Type, Print) M. Waje

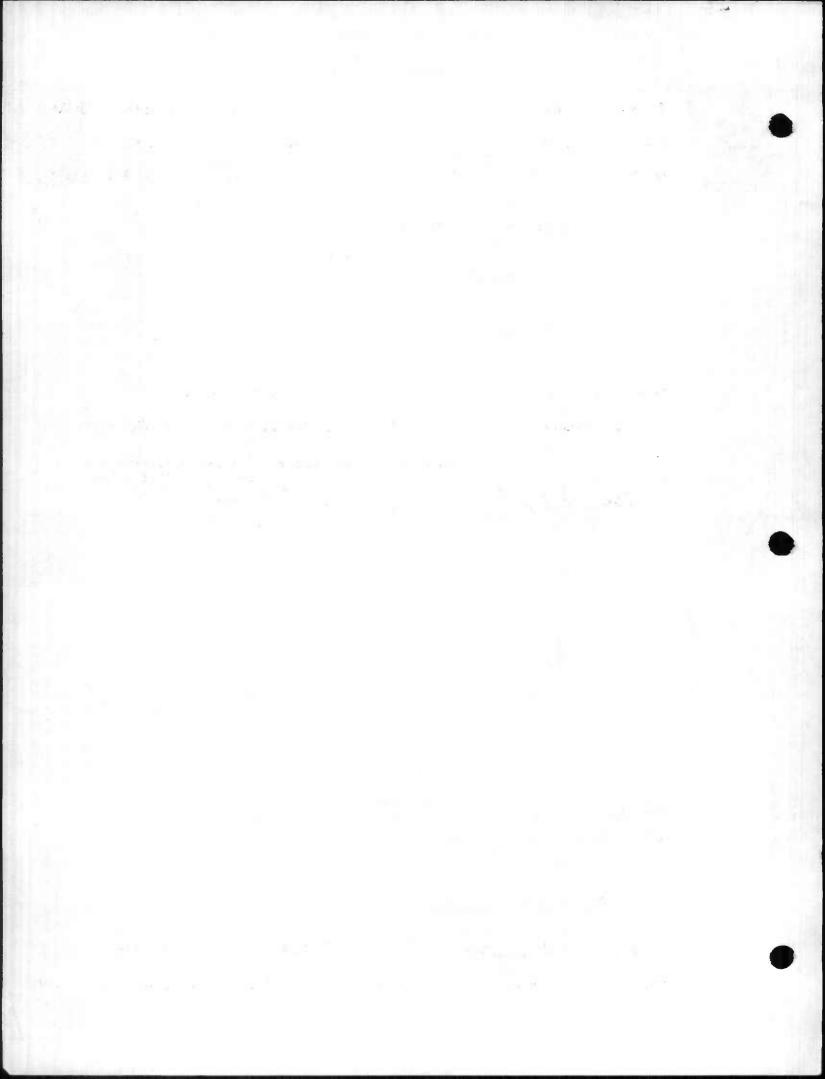
M. D. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture JAN 15

Sicha Davidson



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neral	5			Age (In yrs.	lest birthday)	If Under		If Under 24 Hrs.	8. Dete of Birth (Month, Dey		0	(Stete or Fore
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ct F		MD Mon	tgomery	Whe	eaton						'	☐ Yes 2☐
be notified Director		10e. Street end Number				10f. Zip	Code		1	0g. Citizen of V	What Country?	
- E		2601 Bluhaven C	ourt			209	906-	-3116		U	ISA	
any injury or other traumatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11. Maritel Stetus 1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	∂ No				Rispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Rec Bled Specify	e - American Ir ck, White, etc.	
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Be Be											10)	
To To		Paul J. Saladig				_			ne Mirow			
ana.		19e. Informant's Name/Reletionship	(Type, Print)		19b. Mailin	g Address	(Street	end Number or Ru	rai Route Number	r, City or Town,	State, Zip Cod	le)
5		John J. Kominsk	i (husba					Court,			906-31	
to T	2	20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3	Damoual from Sta	20b. P	lece of Disposemetery, crem	sition (Nam letory or ot	ne of ther plea	ce)	Dete	20c. Location -	City or Town,	Stete
ıryo		4 Donetion 5 Other (Spec		10				metery	1/19/98	Silver	Spring	, MD
글		21. Signature of Funeral Service Lic	gqsee /		22.	Neme en	d Addre	ss of Fecility Fr	ancis J.	Collin	s Fune	ral
any ir		> Xt. 1)	+ //					500 Un		Blvd.	West	
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uneral director, on: To Be C		2 ☐ Accident Investigeti		2 - 5		М	1 🗆	Yes 2 □ No				
the funeral director,		Z C NOOLOOM	d 286. Place of	Injury - At ho	me, ferm, stre	et, factory	, office		28f. Location (S. City or Town	treet end Numb n, State)	er or Rural Ro	ute Number,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Irene M. Kramer January 5, 1998 9:30 AM 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 748 Beall Avenue Rockville Montgomery 5. Social Security Number If Under 1 Yaar if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2X F 024-16-9106 Yrs. Massachusetts April 21,1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 748 Beall Avenue 20850 United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: 1 Never Married 2 Narried 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant Computer 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Melden Surneme) Stefan Obeniski Ursula Mary Krol 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) George F. Kramer/Husband 748 Beall Avenue Rockville, Maryland 20850 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 1998 Montgomery Crematorium Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue M00092 20850 Rockville, Maryland shock, or heart failure. List only one cause on each line. Approximata interval Between Onset end Death Immediete Cause (Final disaase or condition resulting in death) 3 years Gastric Carcinoma Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 INo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

b

Herrs 23a

natural', or

Hygiene.

marked

Department of Health and Important: If Item 27 is m any injury or other traum

Pages 1 and 2 should be nent of Health and Mental

the Medical

Director

Funeral

by

Completed

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the Marylant

72 hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai þ Completed Be Certification: To

physician and the burial-transit The law requires that the death certificate be executed Box 68760. 98 ettending for use as P.O. signed by the eld be deteched for Records, page 2 has certificate Division of Vital Hospital or Attending Physician: 24 hours after death. director, this funeral After Jeral Director: A 24 hours To the Hosp within 24 hou To the Fune completely fil

Medical

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ⊠Neturel 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 🗹 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

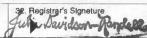
29c. License number 29d. Date signed (Month, Dey, Yeer) D23540 January 8, 1998

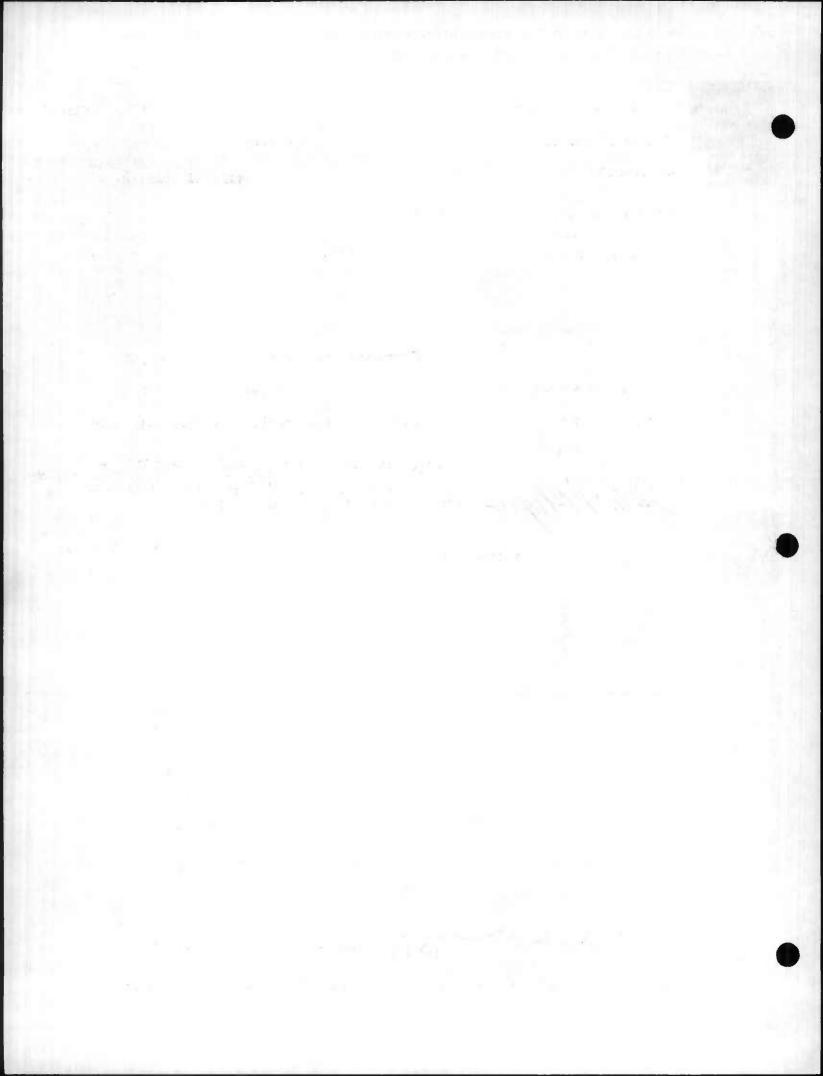
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugh Hill, M.D. 1450 Research Boulevard, Suite 310, Rockville, Maryland 20850

State Registrar

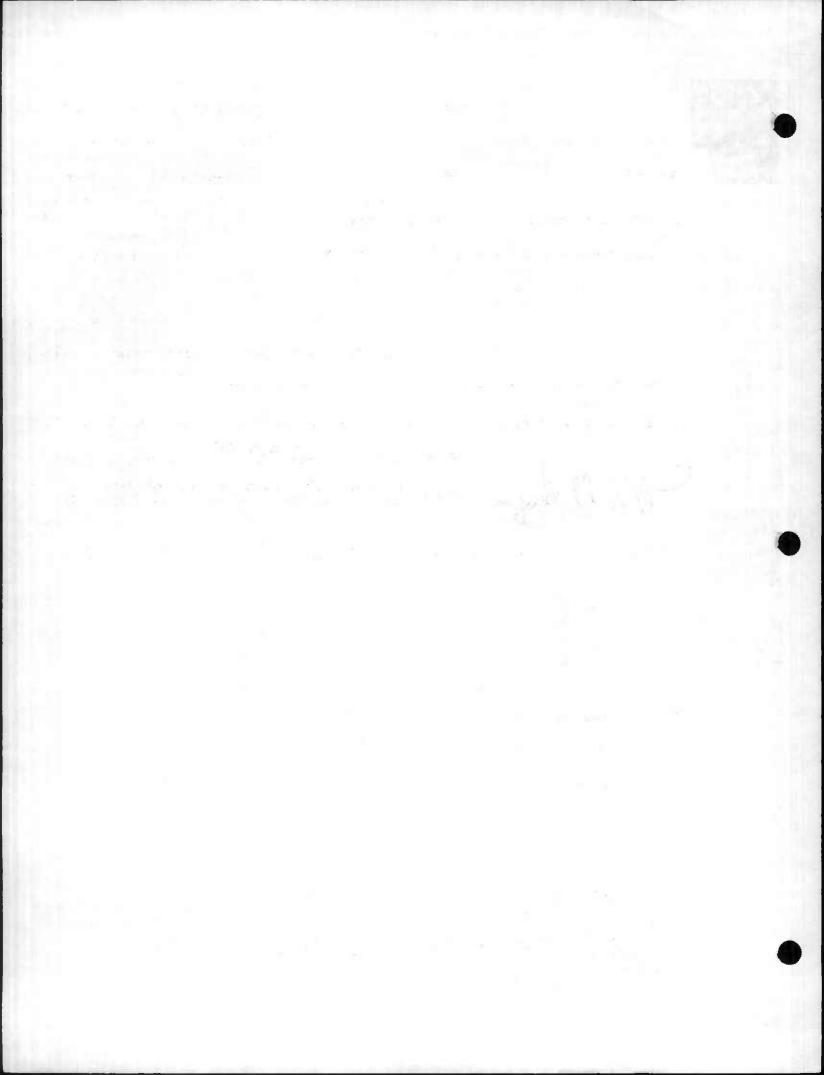
29b. Signature and title of certifiar





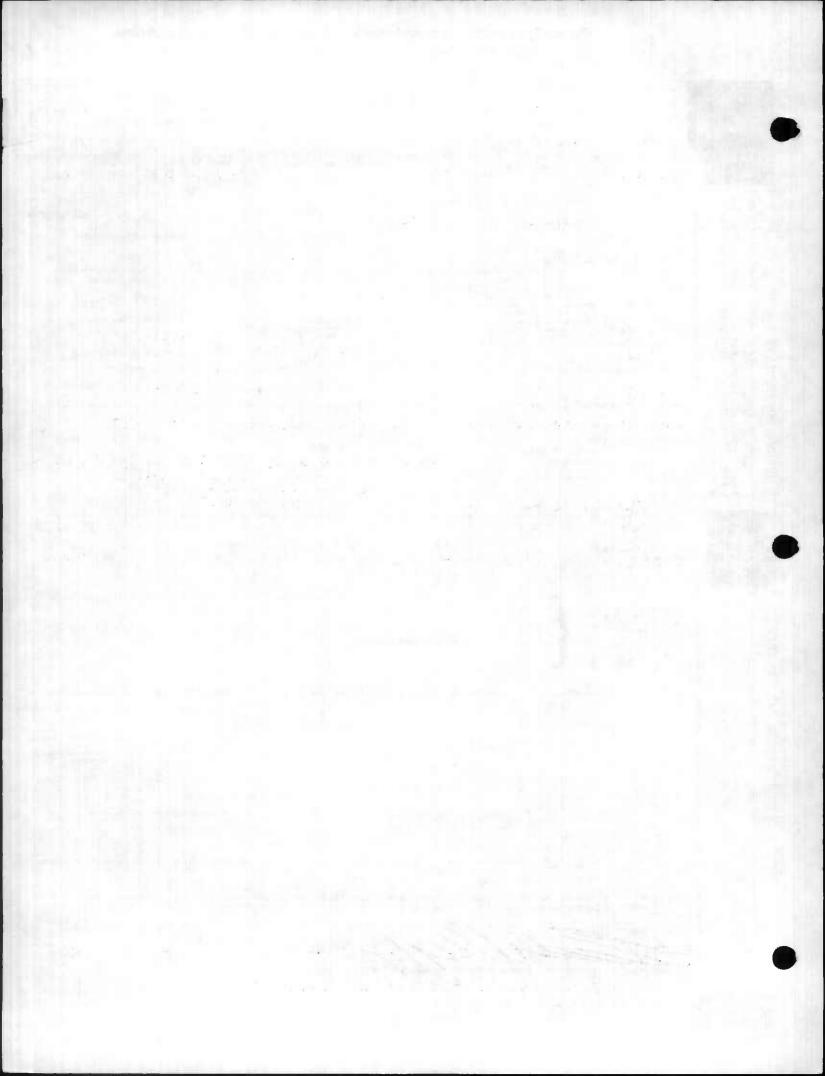
State of Maryland / Department of Health and Mental Hygienen o

				100				ertificate of	Death		g. No.	U	92	.5
П	Physici	an	1. Decedent's Name (Firs							2. Date of Death Month	n Day	Year	3. Time	e of Death
	/Media				Max W.					January	7, 199		11:	02 AM
	Examir	ner	4a. Facility Neme (If not in			per)			4b. City, Town, or I		4c. County			
1		ш	Manor Car	-				I Milleday 1 Many	Chevy Ch			gomer	,	
	Funeral Director		5. Social Security Number 560-64-0303 Usual Residence of Deca	1🛚	M 2 F	Age (In yrs. 78	Yrs.	Months Deys		8. Date of Birth (Month, Day, January		-	ece (Stat try) many	te or Foreign
	show	2	10e. Stete 10b.	County			ty, Town or L					10		City Limits
	the N	ecto	Maryland Mc	ntgome	ry		Chevy	Chase						es 2 <u>1</u> 1110
	with a s	5	8100 Con	nnontin	+ A.z.on	*** #6'	2.5	20815		10	og. Citizen of V			
	ns 23	era	11. Marital Status		12 Was Dacad	ent Ever in II				necify Yes or No-	Unite	d Sta e - America		
21215-0020	within 72 hours effer deeth with the Maryland iene. than "natural", or Itams 23a or 28e-1 show the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 3 Widowed 4 ⊠D	☐ Married	Armed Force 1 X Yes 2 If Yes, Give Yeer or Date	es?	II	If Yes, specify Cut 1 ☐ Yes 2 ☒ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	o Rican, etc.)		k, White, e		
0-10	2 ho	te	(5. D	ecedent's Edu	cation		16a. Dece	edent's Usual Occu	pation		6b. Kind of Bu	usiness/Ind	ustry	
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21	filed within Hygiene. ther than " ant, the We	Completed			4		Fore	ign Servi	ce Office	er U	nited St	ates (Govern	ment
Maryland		Be	17. Father's Name (First, I		1 77					ne (First, Middle, M	laiden Sumam	10)		
Yla	should be nd Mental marked o	2	Wilhelm I			aus				Heymann				
Mai	2000		19a. Informant's Name/Re						t and Number or Ru					10100
	other tr		Deborah L. 1		aughter	20b E	ZI/	East 89th	Street :	SD, New Y			_	10128
Baltimore,	of of		1 ☐ Burial 2 🖾 Crer	nation 3 R	emoval from St	ate 200.	cemetery, cre	ematory or other pla	January !	7, 1998	Oc. Location -			
臣	permit. Peg Department Important: I any Injury o		4 ☐ Donation 5 ☐ C			Moi		ry Cremat	orium, I	nc. B	ethesda	a, Ma	rylai	nd
Ba	permit. Peg Department Important: any Injury once.		Micha	12.8	1000 livs	M008	Re	bert A. Pu	mphrey Fundin Avenue,					
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	/Medical		Immediate Cause (Final disease or condition			(1	/	lar Acc	1 +			i	1	
п	Examiner		resulting in death)	е	Cere		or as e conse		(au)				how	7)
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	tificete be executed ig physician and as the buriel-transit	Examiner	Sequentially list condition	s,		Due to (d	or as a conse	quence of):				1		
68760,	be ex		Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	le J o										
87	physis the	edical	that initiated events resulting in death) Last			Due to (o	r as a conse	quence of):	-					
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0	the d	nysi	Part II. Other significant of	onditions con	tributing to deat	h but not res	ulting in the I	underlying cause gi	ven in Part I.		acco use cor			/
S, P	thet ned b	by P	Branco pr	euma	110					1 U Ye	s 2□ No	3 Prob	ably 4	Unknown
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Re	The law ete hes page 2	шо	12:14		Ditus					1□ Ye	s 2000		Yes 2	√ No
ta		BeC	25. Was case referred to		ritus				26 Place of Dea	th (Check only one			103 2	
\geq	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Н	ospital:	atient 2 🗆	ER/Outpatie	nt 3 DOA Ot	han	ome 5 Reside		er (Snecity	.)	
Jo L			27. Manner of Death		28a. Date of (Month,		28b. Time of			28d. Describe ho				
Ö	Attending In deeth. actor: After by the funer	atic	2 Accident	Pending investigation	(month)	Duy roury	mjury		Yes 2 □ No					
Division	2 4 4 2	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of building	Injury - At he etc. (Specif	ome, farm, st	reet, factory, offica		28f. Location (Str City or Town	eet and Numb State)	er or Rural	Route No	umber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)	ertifying Phya edicai Examin	Ician: To the beer: On the basi	s of examina	wledge, deat tion and/or Ir	th occurred at the ti	me, date and placa opinion, death occu	, and due to the ca rred at the time, da	use(s) and ma te and placa, a	nner as sta and due to	ited. the causi	e(s)
	Mithin Fo th	Me	29b. Signature and site of	certifier				29c. Licen	se number	29	d. Date şigned	Month, E	ay, Year)
	12+1		1-1	1.12	The	- 2	m		03335	7	1/8/	58		
	12.		30. Name and address of	person who co	mpleted cause of	of death (Iten	n 23a) (Type			/	, -,,	-		
			Lee Jan	than	Mush				hery Ch.	ace he	n 2.	815		
	Sta	te	31. Date filed (Month, Day	V°T 2 10		strar's Signa	iture		/ ~~			/		



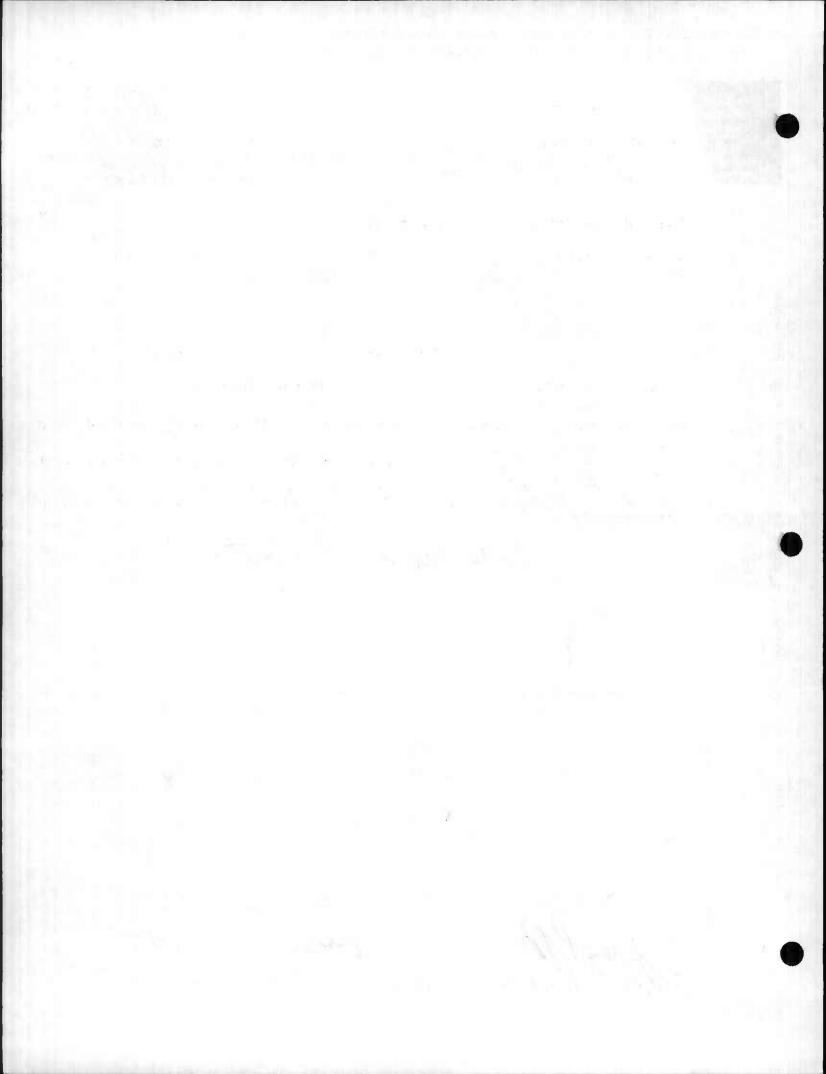
State of Maryland / Department of Health and Mental Hygiene 8 0 1 9 2 6

				Cert	ificate of	Death		Reg. No.	0	1 1 4	U
	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath Day	Year	3. Time	e of Deeth
Physician	Josephine Cl	are Krogma	ann				Janua		1998	10:	47 AM
/Medical Examiner	4a Facility Name (If not institution, giv				71 11 11	4b. City, To	wn, or Location of Dea		unty of Death		
	Montgomery Gener	-				01ne			ontgom		
Funeral Director	5/9-58-33/2	Sex 7. Ag	ge (In yrs. lest b	Yrs.	Months Days		Min. (Month, L	orth Dey, Year) 3, 189			te or Foreig
death with the Maryland ms 23s or 28s-f show Linust be notified at neral Director	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loca	ation					10d. inside	e City Limits
r 28a-f show	MD Montgo	mery	Roc	kvill				γ			res 2€ No
23a or 2	10e. Street end Number 4712 Norbeck Road				10f. Zip Code	20853		10g. Citizen	of What Cou USA	ntry?	
of, or he beam of	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces' 1 Tyes 2 M If Yes, Give Year or Dates:	?			Hispenic Original Dan, Mexicen	gin? (Specify Yes or N , Puerto Rican, etc.)		Race - Ameri Black, White,		1,
naturn naturn sted	15. Decedent's En	ducetion ade completed)	168	. Decede	nt's Usual Occu	pation during most	t of working		of Business/ir	ndustry	
or other traumatic event, the Modell Export of the To Be Completed by	Elementery/Secondary (0-12)	College (1-4or			ind of work done O NOT use retin L Secret		or working		ce of 1 Rese	arch	
Hygi sther out, and	17. Father's Name (First, Middle, Last,)		ne gas	Decre	1	er's Name (First, Midd	le, Maiden Sur	meme)		
Mental H arked out atic ever	James Francis Smi	th				Bes	sie Belle	Johnson	n		
M bu	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Stree		er or Rurel Route Num			p Code)	
27 is	Patricia J. Dunn	(daughte	r) 4	712 N	Norbeck	Road,	Rockville	, MD	20853		
othe othe	20a. Method of Disposition		comet	of Disposi	ition (Neme of atory or other pla	ece)	Date	20c. Locati	Ion - City or T	own, State	3
ent or	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif						ry 1/13/98	SIlve	r Spri	ng. N	iD.
Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, Induce. To Be Co	21. Signeture of Funeral Service Lice			22. H	Name end Addr ome, Inc ilver Sp	ess of Facilit	y Francis O Universi	J. Co.	llins	Funer	
nysician	23a. Part1. E. the disease, or com shock, or mart failure. List only	plications that couse one cause on each i	dahe death. Do ine.					arrest,		Approxi Interval Onset a	mate Between and Death
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n and ial-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	conseque	ence of):				-		
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e attending physician and of for use as the bunal-tra											
igned by the attendibe datached for use by Physician/	Part II. Other significant conditions of	ontributing to death t	out not resulting	in the und	derlying couse g	iven in Part I		d tobacco use			ise of death 4 ⊠ Unknov
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been s should							24a. Wa	as en autopsy rformed?	0	Vere eutop vailable pr completion of deeth?	osy findings rior to of ceuse
page 2							10	Yes 2 N	No 1	☐ Yes	2 No
certificate irector, pag	25. Was cese referred to medical				-	26. Place	of Death (Check onl	y one)			
0 0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 5 ER/C	outpatient	3□ DOA O	ther: 4 Nu	ursing Home 5 Re	sidence 6	Other (Spec	cify)	
he le le	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, Da	ay Year) 28b.	Time of Injury	28c. Inj W M 1[ury at ork?] Yes 2 []		e how injury o	ccurred		
rs after death. al Director: After to led in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of In	jury - At home, tc. (Specify)	farm, stree	et, factory, office	•		(Street end Nown, State)	lumber or Ru	ral Route I	Vumber,
within 24 hours after death. To the Funeral Director: All completely filled in by the funeral Medical Certification	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the best niner: On the basis of end menner	of examination a	ge, death ond/or inve	occurred at the	ime, date an opinion, dea	d place, and due to the	e ceuse(s) an	d manner as ace, and due	stated. to the ceu	se(s)
withir comp	29b. Signeture end title of certifier	FII	1//	-	29c. Licer	nse number		29d. Date s	signed (Month	, Dey, Yes	ar)
	1	AVI	1//	1	D070	99		Janua	ary 13,	199	8
0	30. Name and address of person who	completed cause of	death Utem 25	HType, P				Junuo		,	
	Francis C. Mayle	10215 Fer	//			da. MI	20817				
State	31. Dete filed (March, Day, Year)		rar's Signature	.oaa,	Deenes	aug III	20017				



State of Maryland / Department of Health and Mental Hygiene 8 0 927

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cian lical	N	MARIA LA	BROPOULC	U							JANUA			12:	: 07
iner	48	a. Facility Neme (/	f not institution, g	giva straat and n	umber)				4b. City, To	wn, or Lo	cation of Dee	th 4c. Cou	nty of Deeth		
ı	-	HOLY CROS		TAL	7 Age //n	yrs. last birth	day) If Lind	dar 1 Yaar	SILVE				TGOME		
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	10	0a. State	10b. County		10	c. City, Town	or Location							10d. Insid	le City Li
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Harold Lake-son 9. Method of Disposition 1	ype, Print)				Rachel	L Whitman	n	
e. Method of Disposition 1		19	b. Meiling Ad	Idress (Street	t end Number or F	Rural Route Numb	per, City or Town, Si	tete, Zip Code)
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4/1			Edw	ard Sa	agel Fune		ection ville, MD	20852
e. Pert1. Enter the disease, or comb shock, or heart failure. List only o	lications thet caused t	the death. De						Approximate
snock, or neart failure. List only o	ne ceuse on eech line	θ.						Intervel Between Onset end Death
	Myccord	inl Tm	farati	on				2 David
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et initieted events	c	Oue to (or es	e consequence	e of):				
	ntributing to death but	t not resulting	in the underly	ying ceuse gi	ven in Pert I.			ribute to the cause of death
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nronic obstructur	re pulmona	ry Dis	ease					eveileble prior to completion of cause of deeth?
						10	Yes 2 No	1 ☐ Yes 2 ☐ No
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TLI Fes ZLINO	TY_ Inpatien		Outpetient 3[1 00V	4 Li Noising	Home 5 ☐ Res	idence 6 Other	(Specify)
1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey	Year) 28b	Injury			28d. Describe	how Injury occurred	d
3 Sulcide 6 Could not be determined			farm, street, fe	ectory, office		28f. Location City or To	(Street end Number wn, Stete)	or Rurel Route Number,
a. Certifier 1 Certifying Phy. (Check only one)	ner: On the basis of e	examination e	ge, death occu and/or investig	urred et the ti pation, in my	lme, dete end plac opinion, deeth occ	ce, end due to the curred et the time	ceuse(s) end men , date end place, en	ner es steted. ad due to the ceuse(s)
o. Signeture and title of dertifier	ond mornior store			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
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Suenci	ompleted cause of de							
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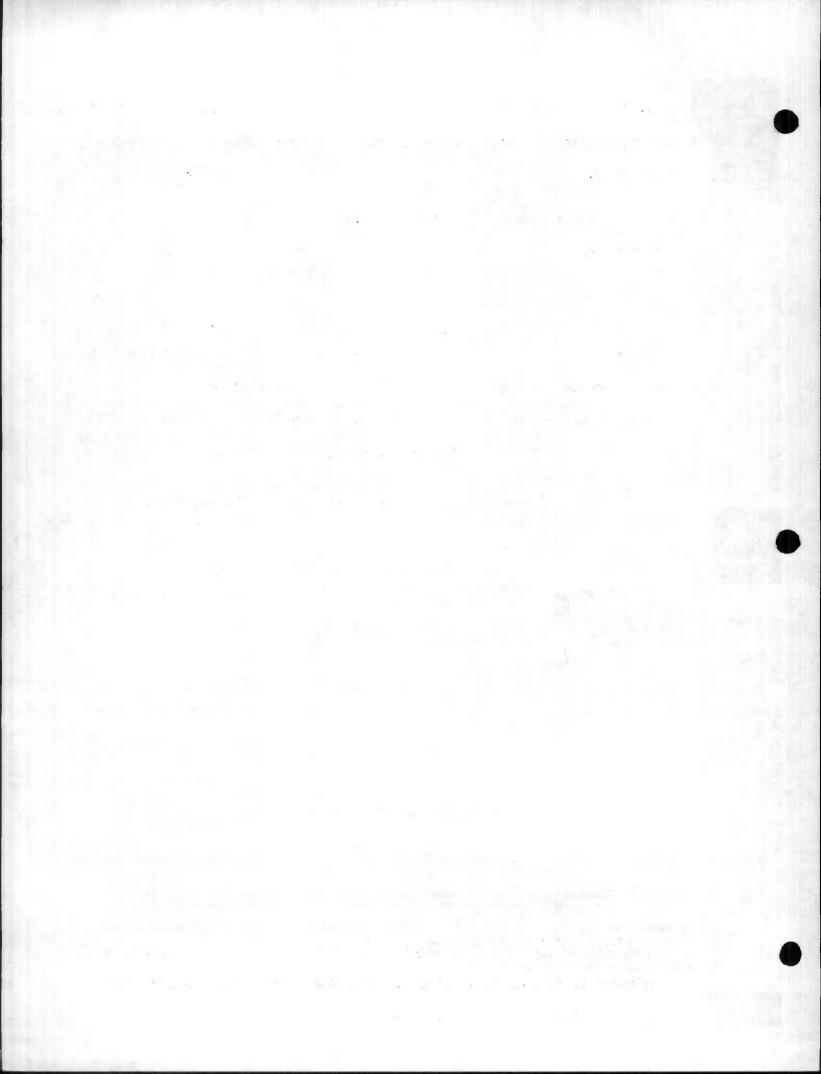
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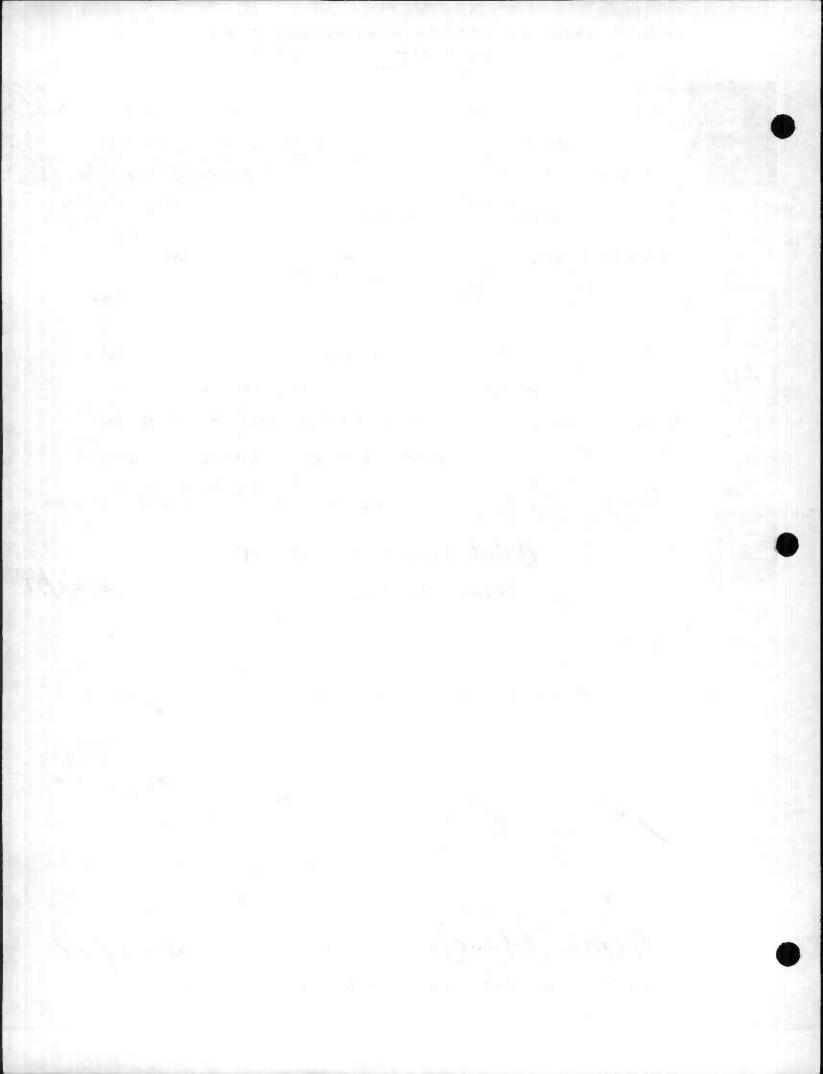
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/Medical Examiner	LTLLIAN 4e. Fecility Name (If not in:		AMBERT street end number	7)				4b. City, Town, or	Janua Location of Dea		998 of Deeth	1:40pm
LAdillilei					on Co	ntor		Forest	vri 110			rao
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du	Elementary/Secondary (College (1-4or	5+)	life.	DO NOT us	e retire	during most of wo	9			
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once	1 XOX	1 1				R. N.	Ho	cton Co.		ans, In		
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Physician/												
Physic	Part II. Other significent co	onditione con	tributing to death I	out not resul	ting in the u	nderlying ca	use giv	en in Pert I.	23b. Did	tobacco uee co	ntribute to t	he cause of death?
4	High Blood	Pressi	ire, Seve	ere St	roke	affec	tino	Brain-	1	Yes 2∏No	3 Proba	bly 4 Unknow
d by P									240 Was	s en eutopsy	24h Wer	e eutopsy findings
page 2 should	stem Funct:	ion								omed?	eveil	eble prior to pletion of cause
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To Be	25. Was case referred to mexeminer?		lospital:				Oth	or.	eath (Check only	777		
	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 L Inpati		R/Outpetier 28b. Time of		^	4 De Nursing		idence 6 Oth		
rtion		Pending nvestigation	28e. Dete of Inju (Month, De	y Year)	Injury	м	Bc. Injur Worl 1 □	k? Yes 2□No	20012001100			
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Hegistra



State of Maryland / Department of Health and Mental Hygiene

aryland Montgome Street end Number Ol Northwest Driv Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced (Specify only highest grad Elementary/Secondary (0-12) Fether's Neme (First, Middle, Lest) athan Late Informant's Neme/Reletionship (7)	Lauderd street end number) pital pital T. Ag M 2 F T. Ag MYE 12. Wes Decedent Armed Forces? 1	e (In yrs. last b 47 10c. City, Tov Silve: Ever in U,S. No 166 19 6 e) 9	Yrs. Manner of Local r Spr 13. Was If Y 1 C a. Deceder (Give kir. life. DO A	ring 10f. Zip Code 20901 as Decedent of Yes, specify Cu ☐ Yes 2 No. Int's Usuel Occuped of work don D NOT use relin	Silver If Under 24 Hours / I	Hrs. 8. Date of B. (Month, D. 4-10-5)	Dey 8, 1 th 4c. Cour Mont linth lay, Year) 10g. Citizen o USA	gomery 9. Birthple Countr Columb 100 of Whet Countr lace - Americal leck, White, et city: Blact Business/Indu	n Indien, tc. k
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State of Maryland / Department of Health and Mental Hygiene 8

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month LUCE BARBARA 2255 1998 HANUARY /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** Months 1 ☐ M 2X F Yrs. Director 79 021-01-7319 10/26/1918 Mass. Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be nothing at 1 ☐ Yes A No Director MD Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò items 23a 4041 Johnson Neck Road death Funeral 21851 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 6 Specify: white 1 ☐ Yes 2X No Specify: ρ 3℃Widowed 4 Divorced "natural". Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry e filed within 7 al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 retail sales Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 12 should be fi h and Mantal H 7 is marked out Be Ralph E. Vittium Violet Douglass 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pegas 1 and 2 Department of Health a important: If item 27 is any injury or other trat once. 2463 Klej Grange Rd., Pocomoke City, MD 21851 David Luce (son) 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 1/7/98 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Holloway-Melson Funeral Home 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately 103 Linden Ave., Pocomoke City, MD 21851 Approximately 104 Approximately 104 Approximately 104 Approximately 105 Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Sep575 IWK Examiner Due to (or es e consequence of): Examiner COPD The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last bunial-tren Due to (or as e consequenca of): Box 68760. physician MW Physician/Medical the Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? been completion of cause of deeth? this certificata has 1 Yes 2 No 1 ☐ Yes 2 No Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Affer 5 Pending 1 Naturel 1 Yes 2 No death. 2 Accident investigation or Attendi aftar death Director: A 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the bests of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner steted. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Yeer) 450 497 VO . 116/98 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

108 PINE BIVER RD

M.s.

32. Registrer's Signature

Julia Davidson-Randelle

State

Registrar

31. Dete filed (Month, Dey, Year)

JAN 0 8 1998

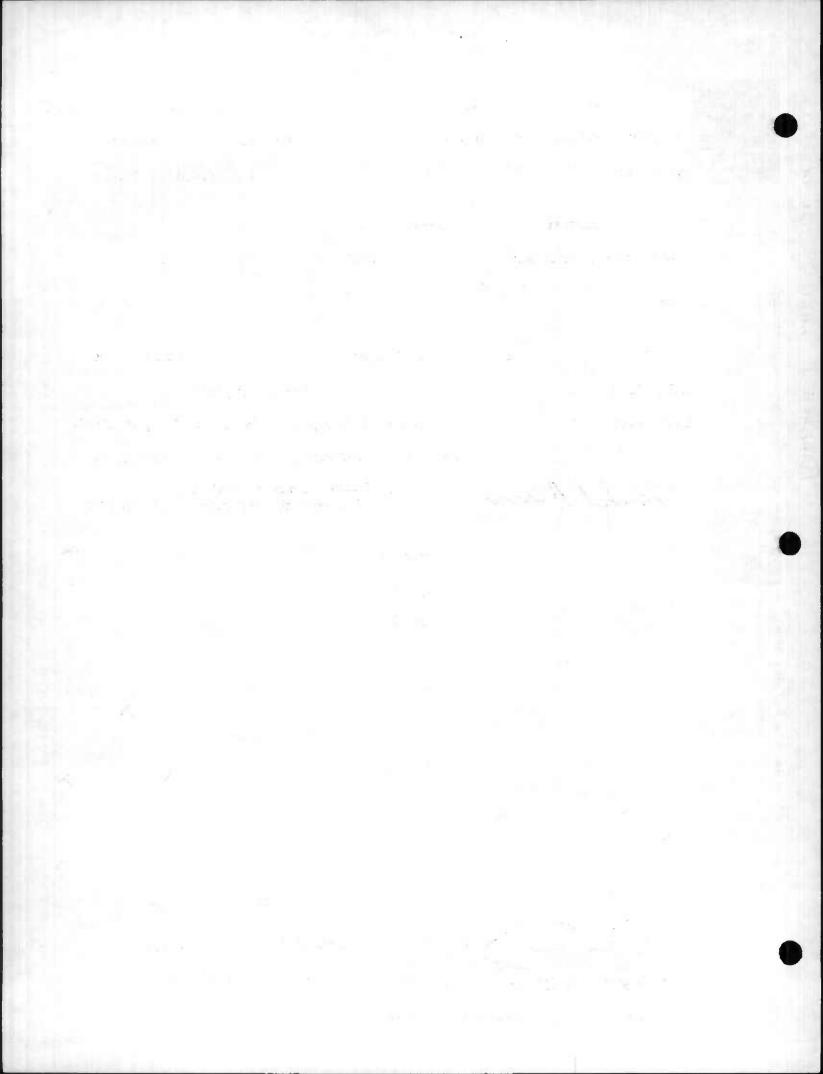
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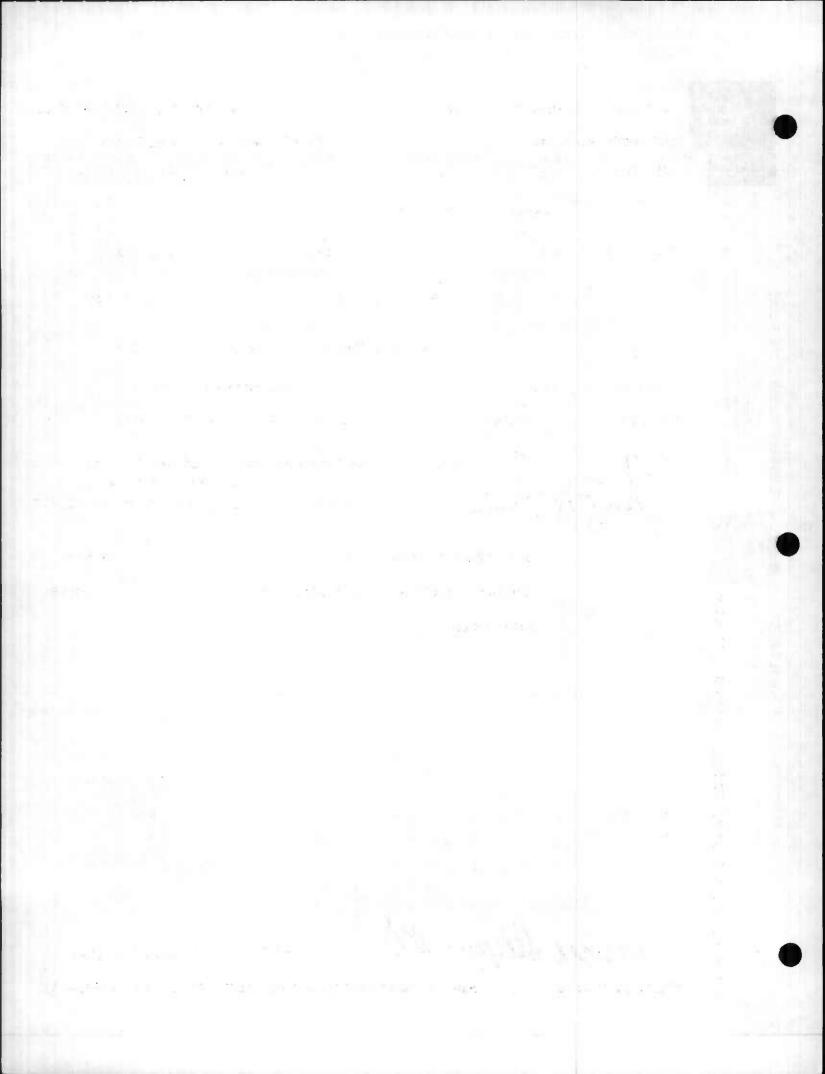
SARBARA



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	the Manager	ect	10e. Street and Nu	mbor					10f. Zip Co	el a				10-	0		
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	9 2 2	un.	11. Marital Status	ried OF Mer	Arme	Decedant Eved Forcas?	10/2	13. V	Vas Decedant Yas, specify	Cuba	an, Maxica	n, Puarto	Rican, atc.)	10-		ck, Whita	lcan Indian, ,, atc.
21215-0020	72 hours efter natural; or ite	by F	1 ☐ Never Mar 3 ☐ Widowed	4.5	If Ya	Yas 2∏ No ıs, Giva rorDatas:	1946	1	☐ Yas 2☐	No	Specify:	:			Specif	v: Whi	te
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Baltimore,	Pages nent of nt: If it		1 X Burlal 2	Cramation	3 Remove t	from Stata	camata	ry, cram	atory or othar	plac							
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39	permit. Depertrimports any Inje		21. Signatura of Fi	unara Samue	Licenside			22.	Nama and A	ddra	ss of Facili	ty	DeVol :	Fune	eral	Home	
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XO	nding use s	n/Medicai			d												
m		cia		4													
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0	been should	Completed											24a. Wa	s an a formac	utopsy I?	а	Vara autopsy findings vailabla prior to ompletion of causa
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1 of	er the	ë	27. Mannar of Dea		28a. [Data of Injury (Month, Day	28b. 1	Tima of	28c.	Injur	y at		28d. Describe	how I	njury occui	red	
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Division	l or Attending lafter death. Director: After d in by the fune	Certification:	3 Suicide	6 Could determ	inad Zoa. r	Plece of Injury	y - At homa, fa	rm, stre	at, factory, off	fice			28f. Location	(Stree	t and Numi	bar or Rui	ra / Routa Number,
ā	pital or Att ours after d eral Direct filled in by	ert	4 Homicida			building, atc.	(Spacify)						City or T	own, S	tata)		
	within 24 hours and To the Funeral I completely filled		29a. Certifier	1X Certifyin	g Phyalcian: To	o the best of	my knowledge	daath	occurred at th	na tin	ne dete en	nd plece	end due to th	e caus	a(s) and m	annar as	statad
	Fur Pur	edicai	(Check only one)	2 Medicai	Examiner: On the	tha basis of a	xaminetion en	d/or inv	astigation, in r	ny o	pinion, das	th occur	red et the time	, date	end placa,	and dua	to the causa(s)
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	CL		30. Nama and add	rass of person	who completed	causa of das	ath (Itam 23a) ((Type, F	Print)								
	*		NORMAN A	. ODYNI	EC, M.D			ONS	IN AVE	NUI	E, #7	05	CHEVY	CHA	SE, M	D 2	0815-4330
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	Registr	ar	Ģ.		330	Jua Va	vidson-A	andel	2								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** 1998 13, Margaret Mary Loftus Jan. 8:22P. /Medical 4e. Fecility Name (If not institution, give street and number)
7-J Crescent Road 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Greenbelt Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Jan. 24, 1907 5. Social Security Number Birthplace (Stete or Foreign Country)
 TOWA **Funeral** 1□M **X**X F Days 213-38-0856 90 Yrs. Director Usual Residence of Decedent the Marylend 10e. State 10b. County Prince George's Hygiene. Hygiene. What than "natural", or Items 23a or 28s-f show ent, the Med cal Examinal multi be notified at 10c. City, Town or Location Greenbelt 10d. Inside City Limits 1XXes 2 □ No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7-J Crescent Road 20770 United States death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Maritai Status 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: White þ 3 XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Prince George's Co. Elementary/Secondary (0-12) filed within College (1-40r5+) Public Schools Teacher 7 is marked other traumetic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file ment of Health end Mental Hy ant: If Item 27 is marked oth ury or other traumatic eventury or other traumatic eventuals. Be Phillip. A. **Boland** F. Katharine **Kelly** 0 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katharine L. Boucher (Daughter) 8 Willow Street Annapolis, Maryland 20a. Method of Disposition

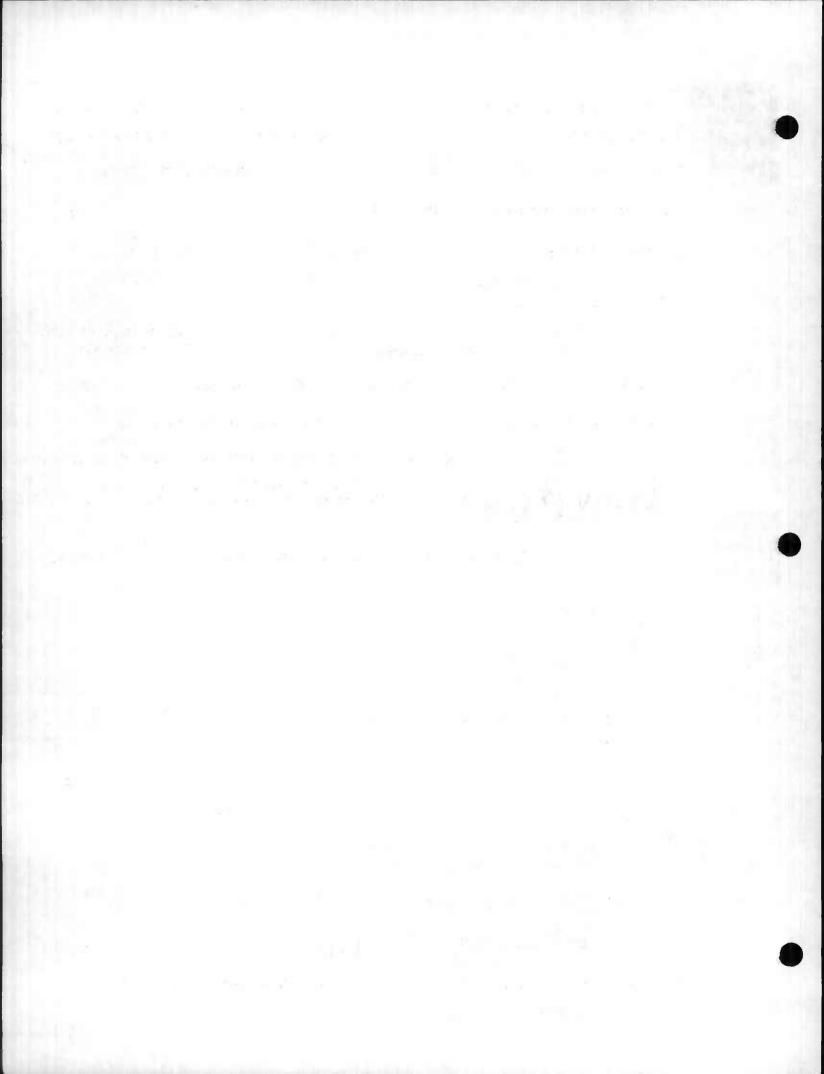
1 → Burial 2 □ Cremation 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Depertment o Important: If any Injury or Gate of Heaven Cemetery 1/17/1998 SilverSpring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Lic Donald V. Bordwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervei Between Onset end Death Physiclan /Medical Immediate Ceuse (Final disease or condition resulting in death) 1 hook Examiner Examine The law requires that the death certificate be executed burial-fransi Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest pue Due to (or as e consequence of) physician s the burial P.O. Box 68760. Physiclan/Medical Due to (or es e consequence of): 89 signed by the ettendin Pert ii. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? peen page 2 hes certificate 1 ☐ Yes XX No 1 ☐ Yes XX No or Attending Physician: director. 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home XXResidence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et 28d. Describe how injury occurred After Naturei 2 Accident 5 Pending investigation efter death. 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) completely filled in by 4 Homicide within 24 hours e To the Funeral D Hospital 29a. Certifier XX Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. the 29b. Signeture end title of profile 29c. License number 29d. Date signed (Month, Day, Year) 20 January 15, 1998

State Registrar

egistrar's Signeture

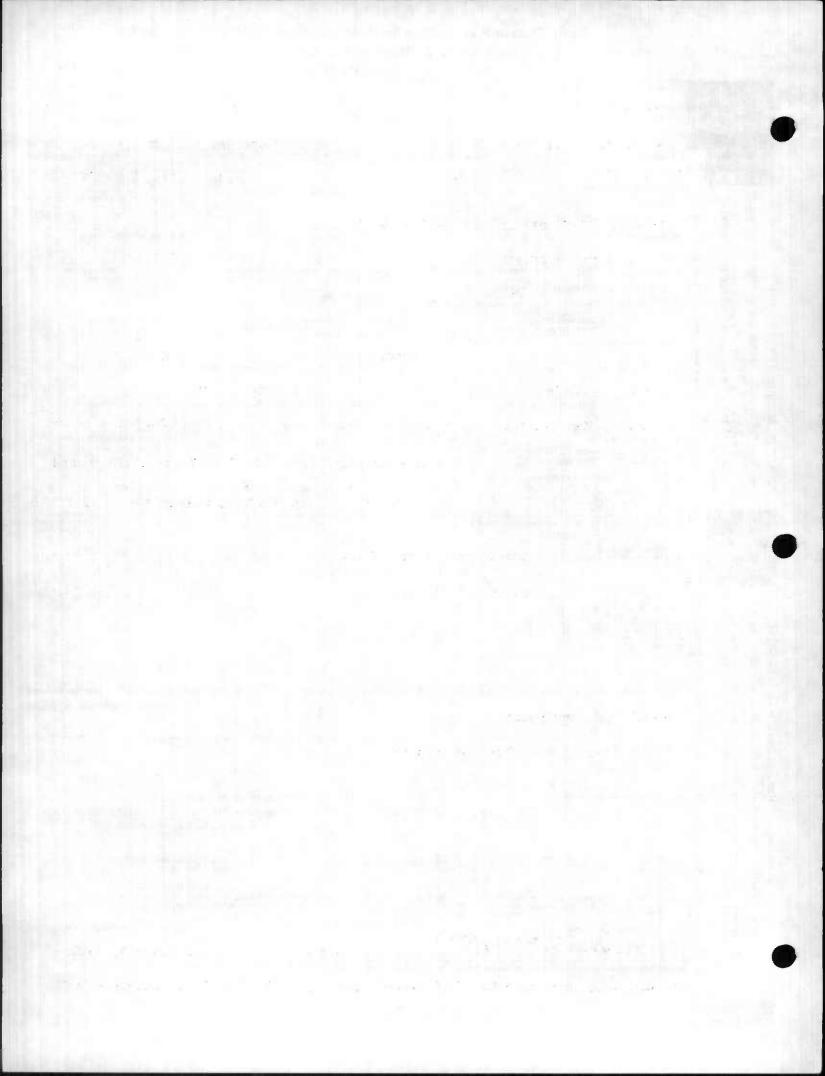
Gabriel B. Jaffe, M.D. 7500 Hanover Pkwy., #105 Greenbelt, Maryland 20770

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)



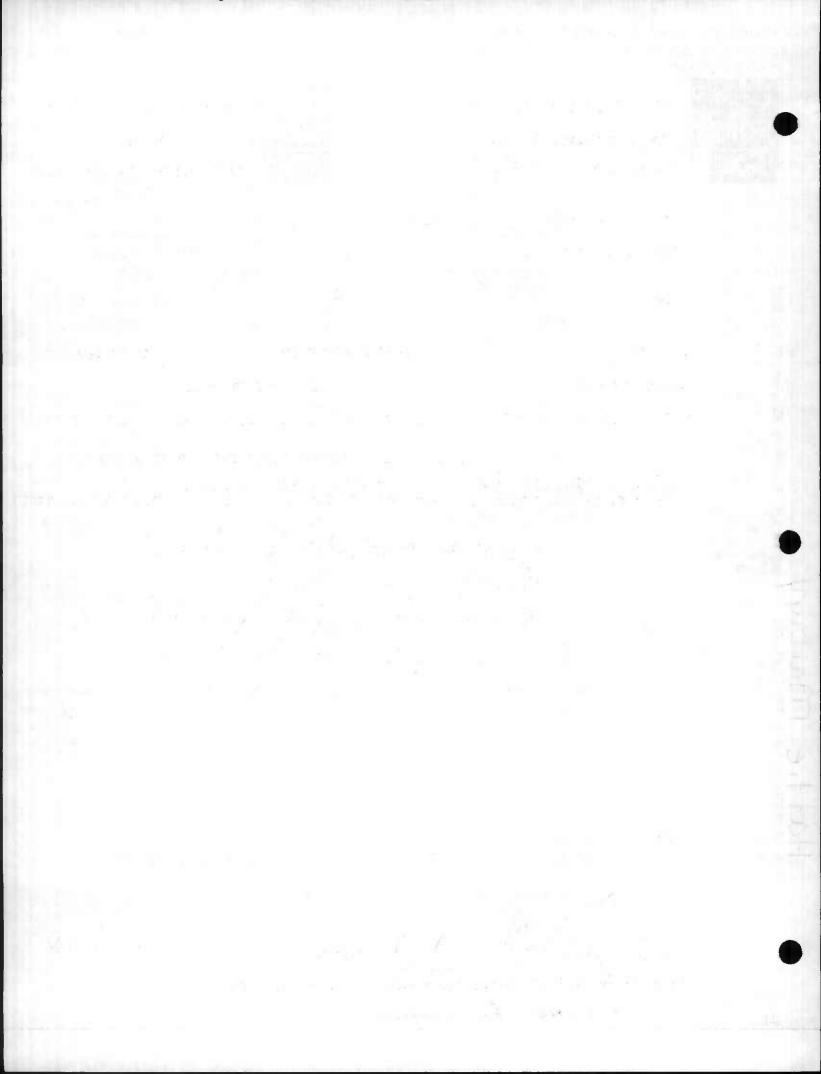
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Re	g. No.	0193	2
	1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day	3. Tin	ne of Deeth
hysician /Medical	Abe Mandell			J		8, 1998		4AM
aminer	4e Fecility Neme (If not institution, give street and	number)		4b. City, Town, or Loca	tion of Deeth	4c. County of	of Deeth	
	204 St. Lawrence Drive			Silver Spri	ino	Mont	gomery	
eral	Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) If Under 1 Year		. Date of Birth (Month, Dey,		9. Birthplece (St Country)	ete or Foreign
ctor	178-05-8790 12 M 2 F	86	Yrs. Months Deys		Feb. 18,		ennsylva	
	Usuel Residence of Decedent							
ector	10a. State 10b. County	10c. City, To	wn or Location					le City Limits
ó	Maryland Montgomery	Silv	er Spring				10	Yes 20 No
Funeral Director	10e. Street end Number		10f. Zip Code		10	g. Citizen of W	het Country?	
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era	11 Merital Status 12. Wes D	ecedent Ever in U,S.		Hispenic Origin? (Speci en, Mexicen, Puerto Ri	fy Yes or No-	14. Race	- Americen Indie	n,
F	Armed	Forces?			cen, etc.)	Bleck	, White, etc.	
by	3 Widowed 4 □ Divorced If Yes,	s 2□No Give r Dates: WW II	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White	
g	15. Decedent's Education	***************************************	e. Decedent's Usuei Occur	pation	1	16b. Kind of But		-
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Be				·				
2	Israel Mandell			Esther	Fibu			
	19e. Informent's Name/Relationship (Type, Print)	19	b. Melling Address (Street					000.
	Nancy Jane Maneval (st			nere Avenue			ng,Maryl	
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal tro	20b. Place cemel	of Disposition (Neme of ery, cremetory or other pla	ice)	Dete 2	20c. Location - (City or Town, Ste	le
	4 Donetion 5 Other (Specify)		awn Memorial	Park 1/1	2/98 R	ockvill.	e,Maryla	nd
	21. Signeture of Funeral Service Licensee	10	22. Name end Addre	ess of Facility				
	> 9/1/ IN	. 0		Collins Fu				
	23a Part 1 Enter the disease or complications th	ot caused the death. Do	500 Univer	sity Blvd.	W., Sil	ver Spr	ing,MD	20901
Н	23a. Part1. Enter the diseese, or complications the shock, or heart failure. List only one cause of	n eech line.	Thor onto the mode of dy	ing, oddir oo oordida ar	oopiiatory orro	, ,	Interve	imete I Between end Death
	Immediate Cause (Final							
	disease or condition resulting in death)	estive Hea	rt Failure				12 M	onths
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Ü	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury c							
edical Examiner	that initieted events resulting in death) Lest	Due to (or es e	consequence of):					
Ne								
and	d							
S	Pert II. Other significent conditions contributing to	death but not resulting	in the underlying ceuse gi	iven in Pert I.	23b. Did to	becco use con	tribute to the ca	use of death?
Physician/M		8 7 H T			1 U Ye	8 2 X No	3 Probably	4 Unknown
by P	Peripheral Neuropathy							
D.					24a. Wes er		24b. Were euto	psy tindings
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mp								05311
				March Street		s 2 No	1 🗆 Yes	ZUI No
Be	25. Wes cese referred to medical examiner?			26. Plece of Deeth (Check only on	Θ)		
10		☐ Inpatient 2☐ ER/C	Dutpetient 3LI DOA	her: 4 Nursing Home				
:uc	27. Manner of Deeth 1 ☑ Naturel 5 ☐ Pending (M	te of Injury onth, Dey Year) 28b	. Time of 28c. Inju	ork?	ld. Describe ho	w injury occurr	ed	
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tiffic	3 Suicide 6 Could not be determined 28e. Ple	ece of Injury - At home,	tarm, street, tactory, office	28	t. Location (Sti City or Town	reet end Numbe	er or Rurel Route	Number,
Certification:	Du Du	itality, etc. (Specify)			Jy G. 10401	, 2.2.0/		
aic	29a. Certifier 1 Certifying Physician: To							
edical	(Check only 2 Medical Examiner: On the							use(s)
Z	29b. Signeture end title of certifier	1.1	29c. Licen	se number	29	9d. Date signed	(Month, Dey, Ye	par)
	In Chen Darse	L, MAD		0676				
	110. 2000 10. 13	/		30673	J	anuary	8, 1998	
	30. Neme end eddress ot person who completed c	ause of deeth (Item 23a	(Type, Print)					
	Michael Glen Harper, M.	D. 7500 H	anover Parkw	ay #201 G	reenbel	t, Mary	land 20	770
tate	31. Dete tiled (Month, Pay, Year) 32 JAN 12 1998	. Registrer's Signature	50					
istrar	JULY TO 1998	Sicha Savidson	- Mandelle					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

						Ce	ertificate	of I	Death		Reg.	No.	U	1936)
Dhorat		1. Decedent's Name (First,	Middle, Li	ast)				. 4		2. Dete of D		Day	Year	3. Time of	Death
Physic /Med		HATTIE CHRI	STINE	E GOMEZ M	ARBURY	Y				January		. 19		7:35 P	M
Exami		4a. Facility Name (If not ins	titution, gi	va street and num	ber)			- 4	b. City, Town, or L			4c. Count	y of Death		
		Physicians Ma	moria	1 Hospital					La Plata			Char	les		
Funeral Director		5. Social Security Number 578-28-4411		Sex 7 1 □ M 2 🖾 F	. Age (in yrs.	. <i>last birthd</i> ay Yrs.	If Undar 1 \ Months D	ays	If Under 24 Hrs. Hours Min.	8. Date of B (Month, L JUNE	Birth Day, Ye		9. Birth	piace (Stata or ntry) HINGTON	Foreig
		Usual Rasidence of Decedor 10a. State 10b. C			10c. Ci	ity, Town or L	ocation							10d. Inside City	
the Marylan 28a-f show	2]	1 ☐ Yes	
the A	Director	MARYLAND CH	ARLES)	MAH	RBURY	10f. Zip Co				10				
th with	al Dir	5700 BRANCH	ALLEY	PLACE				658	3		_		What Coul		
1215-0020 within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Navar Married 2 3 Widowed 4 Div		12. Was Deced Armed Ford 1 Yes 2 If Yes, Giva Yaar or Dat	es? No	J,S. 13.	Was Decedant If Yes, specify 1 ☐ Yes 2	_	ispanic Origin? (Sp in, Maxican, Puerto Specify:	pecify Yas or No Rican, etc.)	lo-		ack, White,	can indian, etc.	
72 hours	ted		edent's E			16a. Dece	edent's Usual O	ccup	ation		16b	. Kind of B	Business/In	dustry	
within 7	Completed	Elementary/Secondary (0		rade completed) College (1-4	4or 5+)	life.	DO NOT use r	etired	ation during most of work f)	king					
2 garage	No.	12TH GRADE				NUI	RSING A	SSI	ISTANT		FF	EDERA	L GOV	ERNMEN	T
and be filed dother event, t	Be	17. Father's Name (First, M	iddle, Las	t)					18. Mothar's Nam	e (First, Middl	ie, Maio	den Sumar	ma)		
arylan should be nd Mental marked o	2	BERNARDO GOM	EZ						ELLA KIN	LEY GO	MEZ				
Aarylar 2 should be 1 and Mental 1s marked raumatic ev		19a. informent's Name/Rei							and Number or Rui						
ore, Mistand 2 other transcorer		GLORIA JOHNS	ON /	DAUGHTER		5700	BRANCH	AI	LEY PLAC	E, MAR	BURY	Y, MA	RYLAN	ID 206	58
Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or any Injury or other traumatic event, the Medical Evangence.		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremi 4 ☐ Donation 5 ☐ Ott			tate	cemetery, cre	osition (Name of other o	r plac	RIAL CEM.	Data 1/15/98			- City or To		
Physician /Medical Examiner		23a. Part1. Enter the disea shock, or heart feilure immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause. Disease or injury				0583 34 th. Do not ar	439 LIV	N F ING	TUNERÁL H SSTON ROA	D, IND	IAN	HEAD	, MAR	Approximate Interval Betwo Onset end D	veen
.O. Box 6876(the death certificate be y the attending physicial	Physician/Medical E	cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other aignificant co	l	contributing to dea	wine	or as a conse	STAR	Se give	en In Part I.					o the cause of	
cords, P w requires that been signed to should be deta	by									24a. Wa	is an ai	utopsy 1?	av	are autopsy fir	
0 8 8 0	Completed											mh	of	ompletion of ca deeth?	
- in in in in in in in in in in in in in		05.14] Yes	2) No	11	☐Yas 2☐ I	No
vision of Vital Rate and a Management of Vital Rate of Vit	ition: To Be		edical rending	28e. Dete of (Month)		ER/Outpatie	-	Other	4 LI Nuising no		sidence			fy)	
Division or Division or To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	286. Place o	f Injury - At h g, etc. (Speci	nome, ferm, si	treet, factory, of	ffice		28f. Location City or T	(Street own, St	t and Num. tete)	ber or Run	al Route Numb) <i>01</i> ,
Hospita 24 hours Funeral letely fille	edical C	29a. Cartifier (Check only one)	rtifying Pi dical Exa	hysician: To the b miner: On the bas and manne	is of axamina	owledge, dear ation and/or in	th occurred at the	he tim	ne, date and place, pinion, death occur	and due to th	e cause e, date	e(s) and m and place,	anner as s , and due to	stated. o the cause(s)	
om p	Me	29b. Signatura and title of c	ertifiar	M		1	29c. LI	canse	e number		29d.	Datesigna	ad (Month,	bay, Year)	
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		The state of the s	D	200		,	D-20	0629)			1 1	100	1 15	,
		30. Mame and address of po							C 100 -	0400					
		Wathen, George,					te 103 Wa	тdс	ort, MD. 2	0603					
St. Regist	ate	31. Date filed (Month, Day,		32. He	gistrar's Sign	Lar Car									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 1:30 AM John Francis Madison Jan. 14 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b City Town or Location of Death 4c. County of Deeth Examiner Charlotte Hall Veterans Home Charlotte St. Mary's Hall 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2□F Deys 577-40-6442 Yrs. Director 71 10 PA June Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at MD St. Mary's Charlotte Hall Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 29449 Charlotte Hall Rd. 20622 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.

27 is marked other than 'r traumatic event, me Ma Elementary/Secondary (0-12) College (1-4or 5+) Power Production Boiler Repairman Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 end 2 should be 1 lent of Health and Mentai I nt: If item 27 is marked of Charles R. Madison Mary M. Heath Madison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Gloria Ann Partlow/Daughter 327 Opequon Dr. Martinsburg, WVA 25401

20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, crematory or other place)

20c. Location - City or Town, State or other 1 20a. Method of Disposition 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from State Important: It any injury o MD Veterans Cem. 1/20/98 Cheltenham, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, PA MO0945 P.O. Box 567 LaPlata, MD 20646 Vair 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finai disease or condition resulting in deeth) Examiner Examiner burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest P.O. Box 68760, Physician/Medicai the Due to (or es a consequence of): USe Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bhknown ate has been signed paga 2 should be da Records, by Completed 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was cese referred to medicel Be 28. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Ursing Home 5 Residence 6 Other (Specify) Certification: To this 28e. Dete of Injury (Month, Dey Yeer) Menner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Aaturel 5 Pending Investigation 24 hours aftar death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) In by 4 D Homicide within 24 hours aft To the Funeral Di completaly filled In Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. the th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AHENDING

State Registrar

31. Date filed (Month, Dey, Year) JAN 16

ASHVINICUMAR JPATELIMD GB PRESTON SQ II 32. Registrer's Signature

WALDORF MD

and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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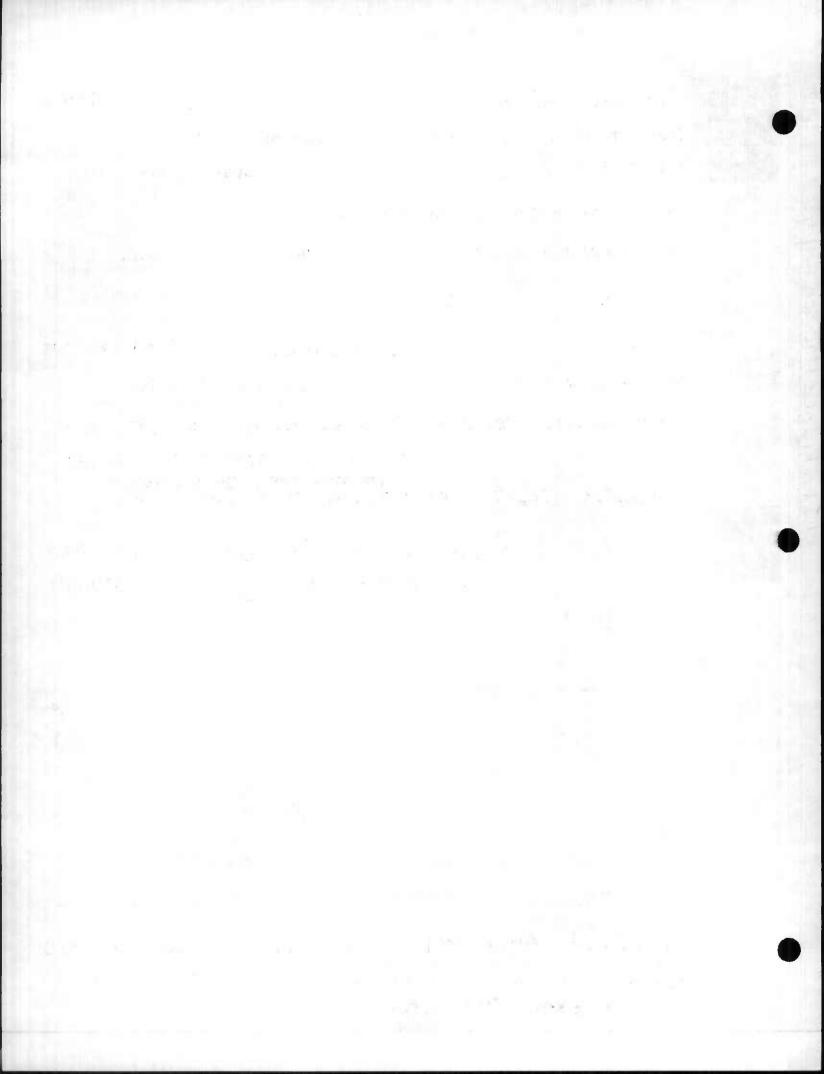
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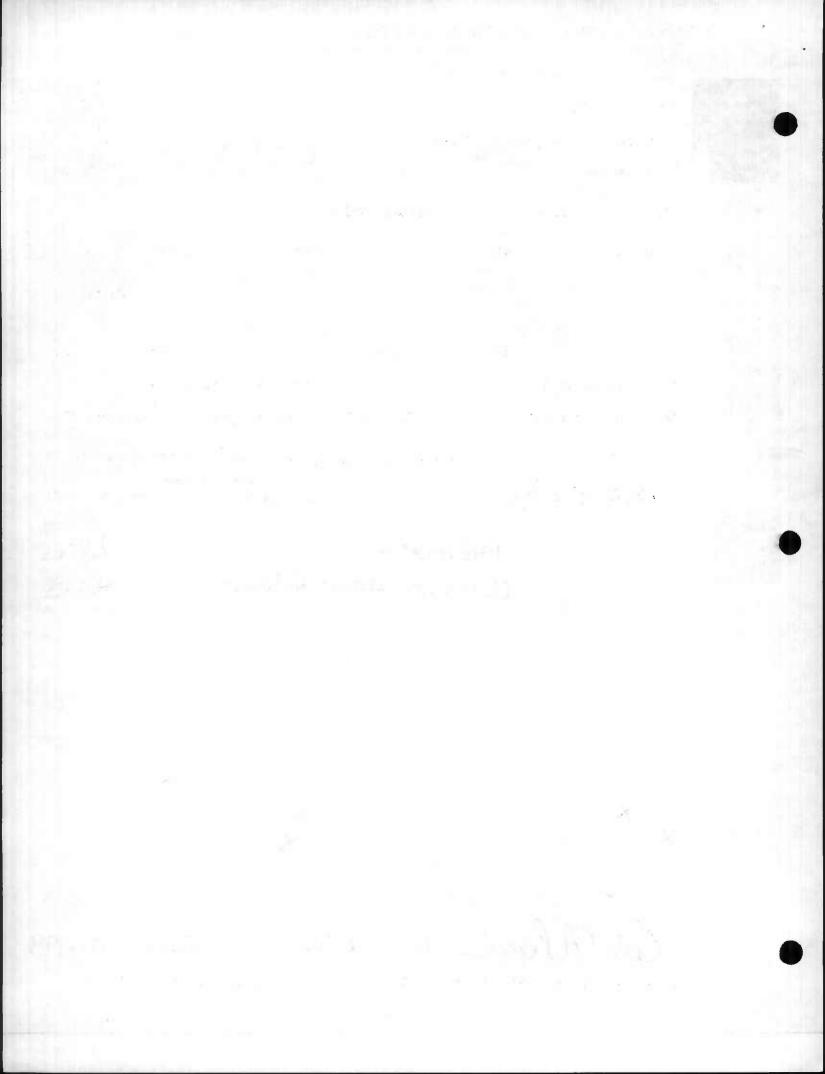


State of Maryland / Department of Health and Mental Hygiene Amend # 5,1/14/98, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer 12:55pm Lotta June Merrill January 11, 1998 /Medical 4a. Fecility Nema (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Mediplex of Montgomery Village Gaithersburg Montgomery 5. Sociel Security Number If Undar 1 Yaar 8. Date of Birth (Month, Dey, Year) May 8, 1910 Birthpleca (State or Foraign Country)
 Idaho 7. Age (In yrs. lest birthdey) **Funeral** Deys 1□M 2XXE Yrs. 87 142-32-4 Director Usuel Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f ehor suical Examiner must be notified at Montgomery Village Md. Montgomery Director 1 Yes 2 No 10e. Streat and Number 10f. Zip Code 10g. Citizen of Whet Country? 20886 United States 19310 Clubhouse Rd. #616 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. Peges 1 and 2 should be filed within 72 hours efter of earl of Health and Mentel Hygiene.
Int: If tem 27 is marked other than "natural", or the interpretation of the hygiene.
Inty or other traumatic event, the Mentel. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Oren Elliott Miller Lotta Victoria Jones 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19310 Clubhouse Rd. Montgomery Village, Md. 20886 Harrison J. Merrill /Husband 20b. Place of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Jan.12 permit, Pege Department of Important: If any Injury or once. Alexandria, Va. 1998 Metropolitan Crematory 21. Signature of Funaral Sarvice Licens 22. Name end Address of Fecility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 23e. Pert1. Entar the diseasa, or complications that caused tha daath. Do not enter the moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximete Interval Between Onset end Death **Physician** PNFUMONIA /Medical Immediate Ceuse (Final disaase or condition resulting in deeth) Examiner Examiner that the death certificate be executed physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Lest Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Pert II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings availabla prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? pege 2 s 2 No certificete Division of Vital tal or Attending Physician: The star death.

Is after death.

In Director: After this certificate of in by the funeral director, pe Be 25. Wes case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Homa 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end mannar stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medicai 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 20 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Gabriel A. Berrebi M.D. 15200 Shady Grove Rd. #305 Rockville, Md. 20850 31. Dete filed (Month, D 320 Registrar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Month 12.42 PM Jenner 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Balti May If Under 24 Hrs. Baltimore Adams, Cowler 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Dev. Year) July 20, 1925 9. Birthplace (State or Foreign Country) Washington D.C. 7. Age (In yrs. last birthday) 150 M 2□ F Months Deys Hours Yrs. 578-24-9255 72 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2X No Charles Maryland Indian Head 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3675 Mount Aventine Rd. 20640 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 DWidowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Elevator Company Elevator Mechanic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Patrick Myles Rebecca J. Walsh 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 38883 Wanda Lane, Mechanicsville, Md. 20659 Thomas M. Myles 20b. Place of Disposition (Neme of cemetery, crematory or other place) January 13, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Charles Cemetery Indian Head, Maryland 22. Name and Address of Fecility Williams Funeral Home, P.A. 21. Signeture of Funeral Service Licensee M00668 4270 Hawthorne Rd., Indian Head, Md. or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, List only one cause on each line. 20640 Approximete Intervel Between Onset end Deeth Donald of Whigh MD immediate Ceuse (Finel CERTIFICATION APPROVED BY MEDICAE EXAMINER 21 disease or condition resulting in deeth) Due to (or eş e consequence of): Epidural God Hematoma 23b. Dld tobecco use contribute to the cause of deeth? 1 | Yes 2 No 3 | Probably 4 | Unknown 24a. Wes en eutopsy performed?

Physician /Medical Examiner

physician and the burial-transit

attending p

2

signed b

page 2

funeral

After

or Attending

death.

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

Box 68760

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

10e. State

Director

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "I any Injury or other traumatic event, the Mess poines.

72 hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

4 Homicide

29b. Signature and fit

31. Date filed (Month, Day, Year)

Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) examiner 1 1 Yes 2 □ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work?

24b. Were eutopsy findings evailable prior to completion of ceuse of deeth?

2 No

1 ☐ Yes 2 ☐ No

Venic

5 Pending investigation Notember 18, 19973: 30 PM 1 Naturai Accident 3 ☐ Suicide

1 Yes

29a. Certifier (Check only one)

28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, building, etc. (Specify)

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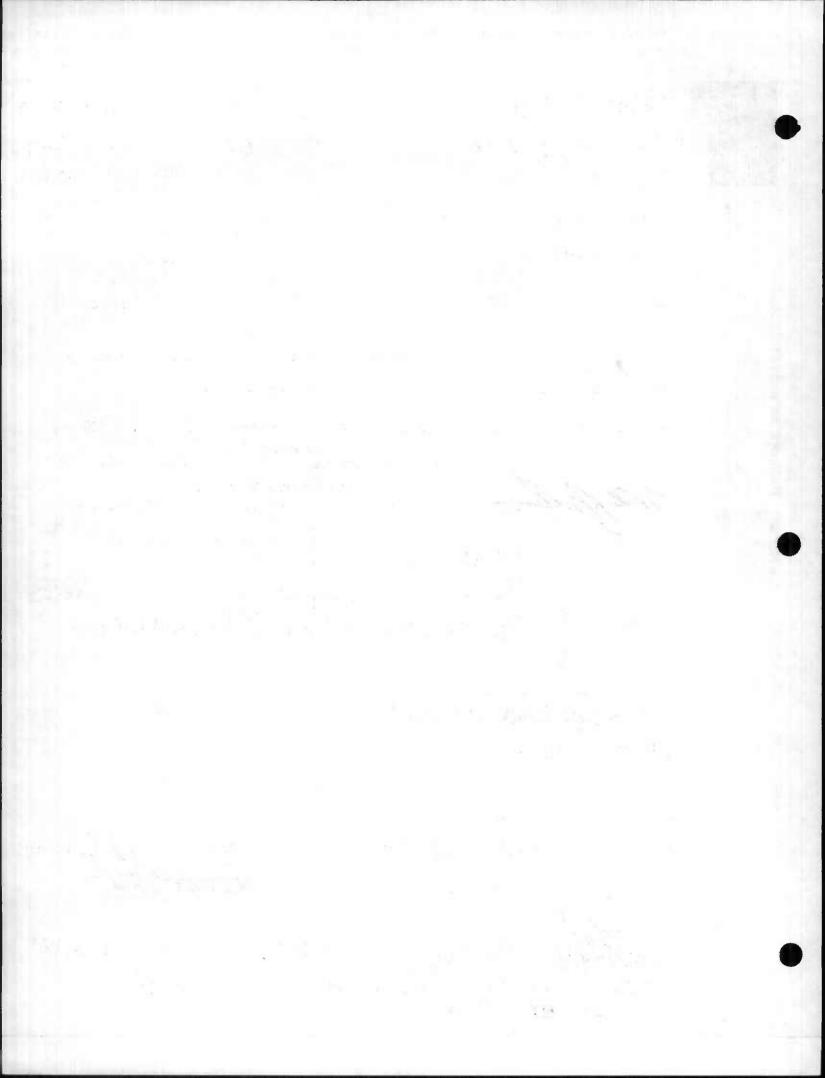
SICIAN

29d. Date signed (Month, Dey, Yeer)

person who completed cause of death (item 23e) (Type, Print)

Shock Trauma Center

State Registrar



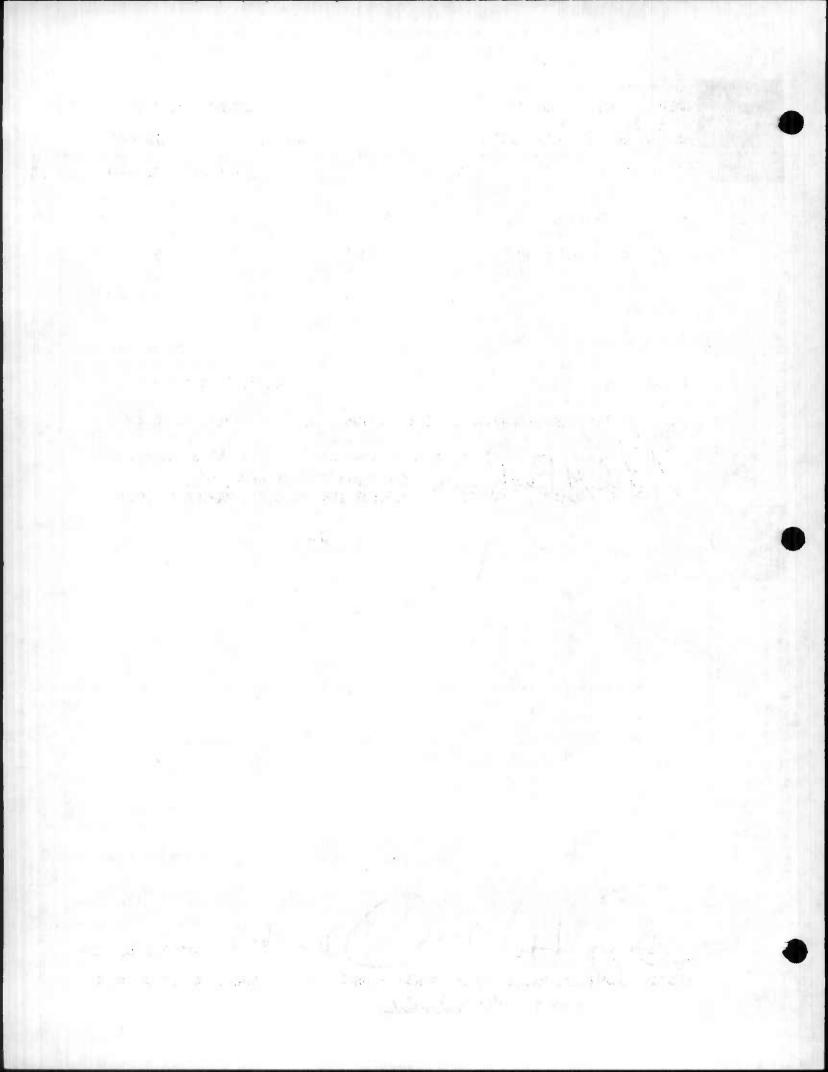
		1. Decedent's Neme	e (First, Middle, L	ast)					2. Dete	of Death	No.	Yaer	3. Time of Death
hysicia /Medic	al	LA FLEUR			ABEL			4h Cihi Taum	JANU	ARY :	7, 19	98	4:37 PM
xamin	er	4a. Facility Name (f	RWICH DR		er)			4b. City, Town, o		Death	4c. County	ARLES	
ineral ector		5. Sociel Security N 093-26-2 Usuel Residance of	2916 6.		Age (In yrs.	lest birthdey) Yrs.	If Under 1 Y Months D		n. 8. Data of	of Birth h, Dey, Ye 9, 1	ar)	_	oce (Stete or Foreig y) ORK
show		10a. State	10b. County		10c. Cit	ty, Town or Loc	ation					100	d. Inside City Limit
28a-fa	ctor	MARYLAND	CHARLE	ES		WALDORI	F						1 □ Yas 🏋 N
I De n	Directo	10e. Street end Nur 4614 HAR	nber RWICH DRI	VE			10f. Zip Co	01-3228		10g.	U.S.	Whet Countr ▲	y?
Even o	by Funeral	11. Meritel Stetus	ed 2 Married	12. Was Deceda Armed Force 1 Yes 2 If Yes, Give Yaer or Data	s? No			t of Hispenic Origin? Cuban, Mexicen, Pu	(Specify Yes of arto Rican, ato	or No-	14. Rac	e - Americe ck, White, et	tc.
merkad other than "natural", metic event, me Medical Ex	Completed	(Spec Elementery/Seco	15. Decedent's E ify only highest gr ndery (0-12)		or 5+)	(Give k life. D	ent's Usuei O kind of work d O NOT usa n	lone during most of vetired) DLER			F00D	SERV]	
ad oth	Be	DANFORD	(First, Middle, Las					18. Mother's N		iddle, Maid	den Sumem	10)	
Tar.	2	19e. informent's Na				19b. Meiling	g Address (S	treet end Number or		umber, Ci	ty or Town,	Stete, Zip C	Code)
n 27 is				JR, JR./SO				CH DRIVE,	_			601-32	
Important: If Item 27 any injury or other tr once.			memation 3	Removal from Sta	te	Place of Dispos cematary, cram	atory or otha	GARDENS	Date			City or Tow	n, Stata
injury		11	Other (Special Service Line	nated /	HIKIN	-		ddress of Fecility	1/10/1	.990	MALDUI	אין, אין	AKILAND
	- 1	1	3 . 1 . 4	1 1 7 14	61 4			T FIMEDAL	LIONE	TRIO	DAGE	T 0	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** (NMI) 5:10 PM MANILI JANUARY 11, 1998 /Medical 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WALDORF HEALTH CARE CENTER WALDORF CHARLES H Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Year) | 9. Birthplace (Stete or Foreign (Month, Dey. Year) | 9. Birthplace (Stete or Foreign (Month, Dey. Year) | 1915 | Washington DC 5. Social Security Numbar 7. Aga (In yrs. lest birthday) Funeral 1MM 2□F Yrs. 577-18-7986 Director 82 Usual Rasidance of Decadant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiena. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner mans to notified at Director 1 ☐ Yas 2 ☑ No Maryland Charles La Plata 10e. Street and Number 10f. Zip Cods 10g. Citizan of What Country? 108 Quailwood Parkway 20646 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 □ Divorced Yaar or Dates: WWII 15. Dacadant's Education (Specify only highest grede completed) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Glazer Glass Company 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Joseph Manili Lucia Strappelli 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health ar important: if hem 27 is any injury or other traugonce. Nicola P. Marchese - Nephew 20a. Mathod Disposition 108 Quailwood Pkwy, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crametory or other piece) 20c. Location - City or Town, State 1 D Burn 2 ☐ Cremation 3 ☐ Ramoval from Stata 1-14-98 Suitland, MD 4 000 5 Othar (Specify, Cedar Hill Cemetery 21. Signatu THE HUNTI FUNERAL HOME, INC. MARK G. **BROHAWN** M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batw Onset end Death **Physician** Immediate Ceusa (Final diseasa or condition rasulting in daath) /Medical July Examiner Attending Physician: The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate nas been signed by the page 2 should be datached 23b. Did tobecco usa contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ Completed 24a. Was an autopsy parlormed? 24b. Wara autopsy findings eveileble prior to completion of cause of death? 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical Be 26. Placa of Daath (Check only one) axaminar? 2 No Othar: 4 2 1 ☐ Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Homa 5 Rasidance 6 Othar (Specify) this funeral Medical Certification: 27. Manger of Deeth 28a. Data of Injury (Month, Dev Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Ather Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant death after death 3 Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stata) 49 4 T Homicide ö To the Hospital within 24 hours a To the Funeral D ertifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Data signad (Month, Dey, Year) JANUARY 12, 1998 son who complated causa of daath (itam 23a) (Type, Print) WATHEN, MD., 11345 PEMBROOKE SQUARE #103, WALDORF, MARYLAND 20603 31. Data filad (Month, Day, Year) 32. Ragistrar's Signature State JAN13 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth 8 Day JAN. 1998 2:00 P R. MILES CLAUDINE 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Levindale Geriatric Ctr & Hospital Baltimore BALTIMORE 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Date of Birth Month, Day, Year) Mar. 16, 1947 5. Sociel Security Number 9. Birthplece (State or Foreign Maryland 1 M 2 X 50 217-50-9902 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City LlmIts MD Baltimore 1 Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4004 Fords Lane, Apt. TC 21215 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Dietician Nursing Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Theodore R. Harris Estella M. Sturgis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Smith (Sister) 14 Roberts Ave., Catonsville, MD 21228 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State Woodlawn Cemetery 1/16/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) by of Funeral Service License 22. Name end Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part. Enter the descape, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) PNEUMONIA JAY5 Due to (or es e consequence of): SCHEMIC BRAIN WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): INFARCTION MYOCARDIAL WEEKS Due to (or es e consequence of): 23b. Did tobecco use contribute to the ceuee of deeth? 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No. 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral', or Items 23a or 28a-f shore Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If lean 27 Is marked other than "natural; or thans 23s may future yor other treumatic event, its Medical Examinar must

Baltimore, Maryland 21215-0020

Box 68760.

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Physician/Medical Examiner use es the bunal-transi requires that the death certificete be tot signed by the a by certificate has been si Completed The law page 2 s or Attending Physician: Be T₀ this Certification: After s efter dea.

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2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. (Check only one)

29c. License number

D 25610

State Registrar

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVERDERE AVE BATIMORE MD 21215

29d. Date signed (Month, Day, Yeer)

JAN 8, 1998

31. Dete filed (Month, Di

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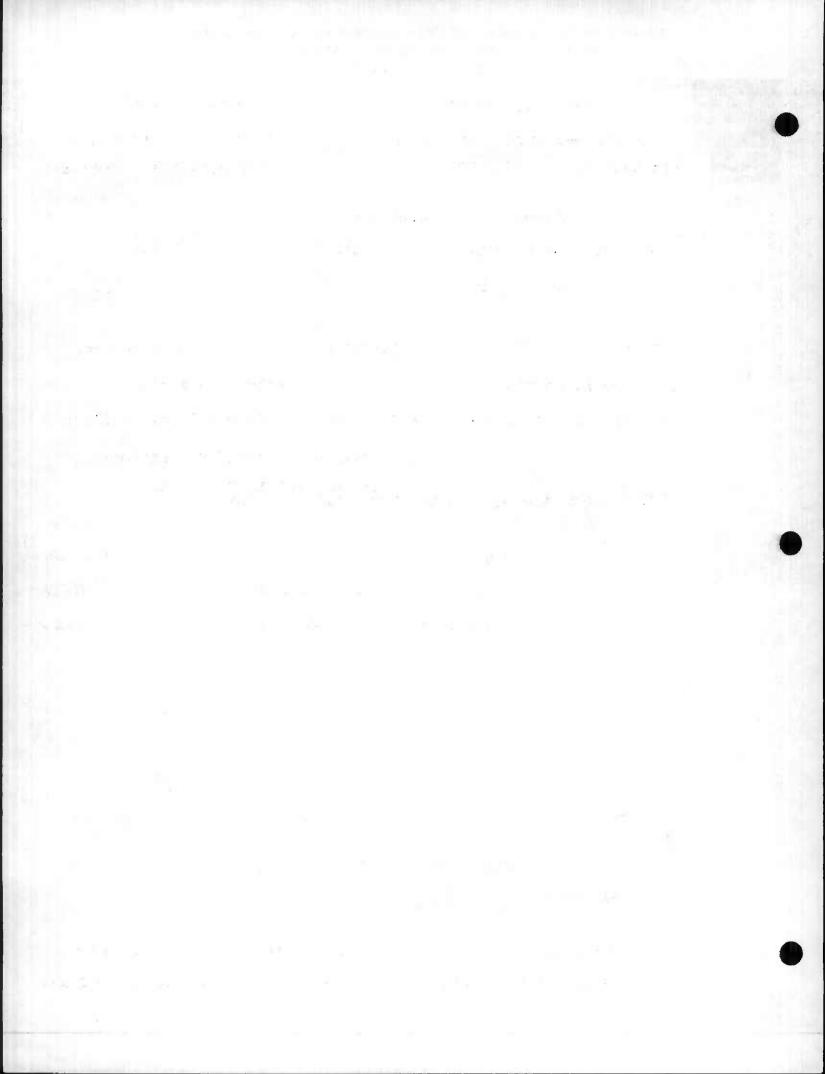
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29b. Signeture end title of certifier

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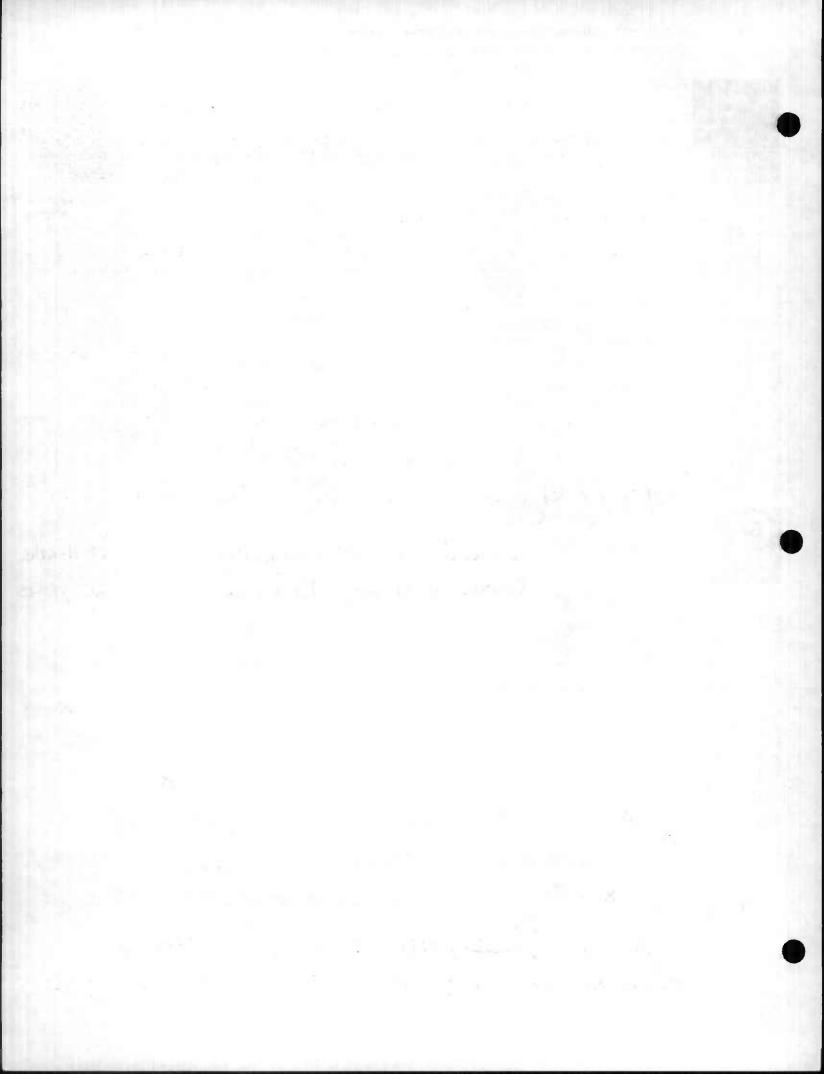
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State of Maryland / Department of Health and Mental Hygiene 8 0 | 9 4 3

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Date of Deeth **Physician** /Medical 4e. Eacility Name (If not institution, give street 4c County of Deeth ocation of Death Examiner 5. Sociel Security Number 7. Age (In yrs. last birthdg) 9. Birthplece (State or Fereign 8. Date of Birth (Month, Dey, Year) **Funeral** Days West Virginia Director 235 36 5445 Oct 20, Usual Residence of Decadent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD P.G. Upper Marlboro 1 ☐ Yes 2 ₩ No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20772 United States 8064 Croom Road Funeral death 12. Was Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Maritel Status ☐ Never Married 2☐ Married altimore, Maryland 21215-0020 1 ☐ Yes XNo Specify: Widowed 4 □ Divorced þ Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is merked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) NSA Office / Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mary Candas Queen Taylor Wayne Weaver 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Stepen D. Oliver, Son 8064 Croom Road, Upper Marlboro, Md 20772 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Md Lee Crematory Jan 8, 1998 22. Name end Address of FacilityLee Funeral Home, Inc 6633 Old 21. Signature of Eugeral Service Lice Alexandria Ferry Road, Clinton, Md 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one ceuse on eech line. Approximete interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pulmonary Edema diseese or condition resulting in death) Examiner Examiner attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In deeth) Last Due to (or es e consequence of): P.O. Box 68760, arrythma Physician/Medicai Due to (or as a consequence of): End Stage Renal Disease Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy findings evellable prior to completion of cause of death? 24e. Was en eutopsy peed page 2 certificate 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 27. Magner of Deeth 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred A hours after dea.

*rel Director: Attach 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ♥☐ Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es steted.
2☐ Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Registrar

State

31. Date filed (Month, Day, Year) JAN 1 4 1998

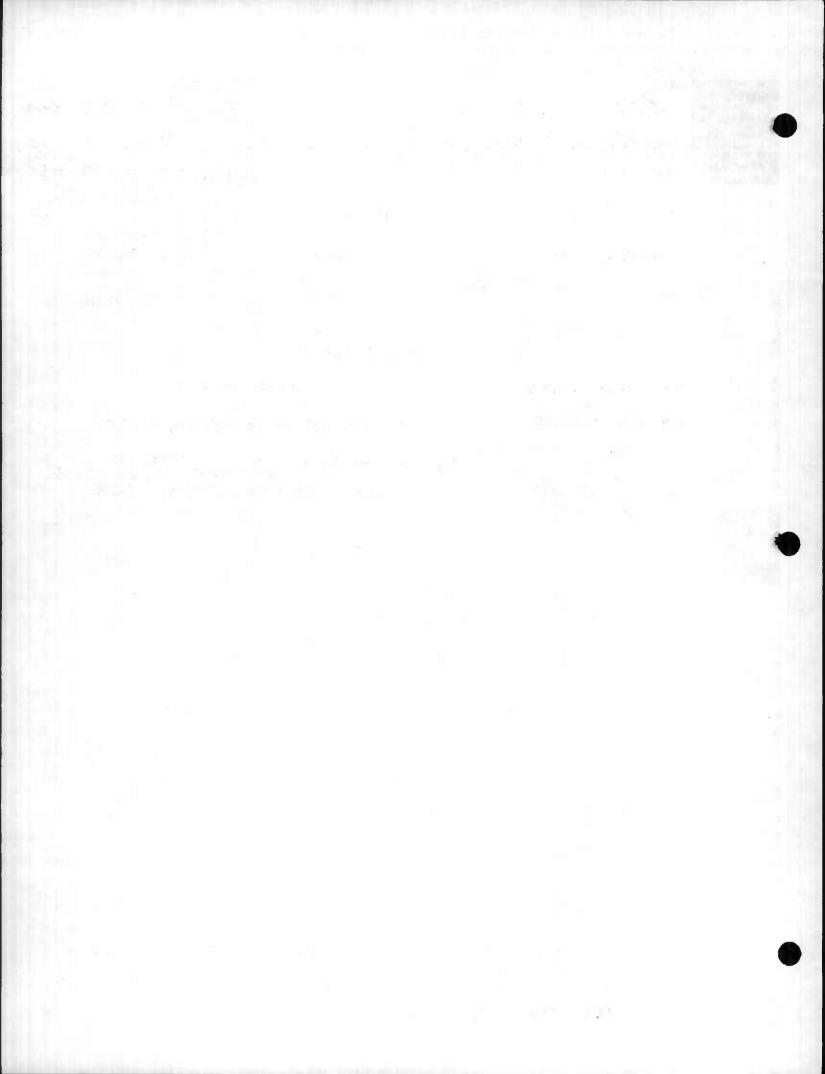
MARIA

32. Registrer's Signature Jahr Stocker Randell DOOS 2023

10403 Hospital Dr. Suite 103

M.D

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ROMERO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 13, 1998 Jesse Orlansky January 2:00 AM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 7727 Rocton Avenue Chevy Chase Montgomery | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | October 26, 5. Social Security Number 6. Sex 1 XM 2□ F 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. lest birthday) Yeer) Months Yrs. 054-24-0502 83 Usual Residence of Decedent 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7727 Rocton Avenue 20815-3915 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 [AYes 2 □ No If Yes, Give Year or Dates: WW I I 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 🕅 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Institute for College (1-4or 5+) 5+ Elementary/Secondary (0-12) Behavioral Scientist Defense Analyses 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Morris Orlansky Celia Fudelowitz 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7727 Rocton Avenue, Chevy Chase, MD Grace Orlansky (Wife) 20815-3915 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1-13-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Carcinoma of the Colon 4½ years Due to (or es a consequence of) Due to (or as e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were eutopsy findings aveilable prior to completion of ceuse of death?

Physician /Medical Examiner

attending physician and for use as the burial-transit

signed by t

peen

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

page 2

by

Completed

Be

2

Certification:

Medical

that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examinar must be notified at

filed within 72 hours after of Hygiene. Wher than "natural", or the

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If tem 27 is marked other tha any fillury or other traumetic event, that, once.

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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the Marylank

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. Wes en autopsy performed? 1 ☐ Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 🖾 Residence 8 □ Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier (Check only one)

1🛱 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

JAN 14 1998

29c. License number

29d. Date signed (Month, Dey, Year)

1 □ Yes 2 No

Kalesela

D14646

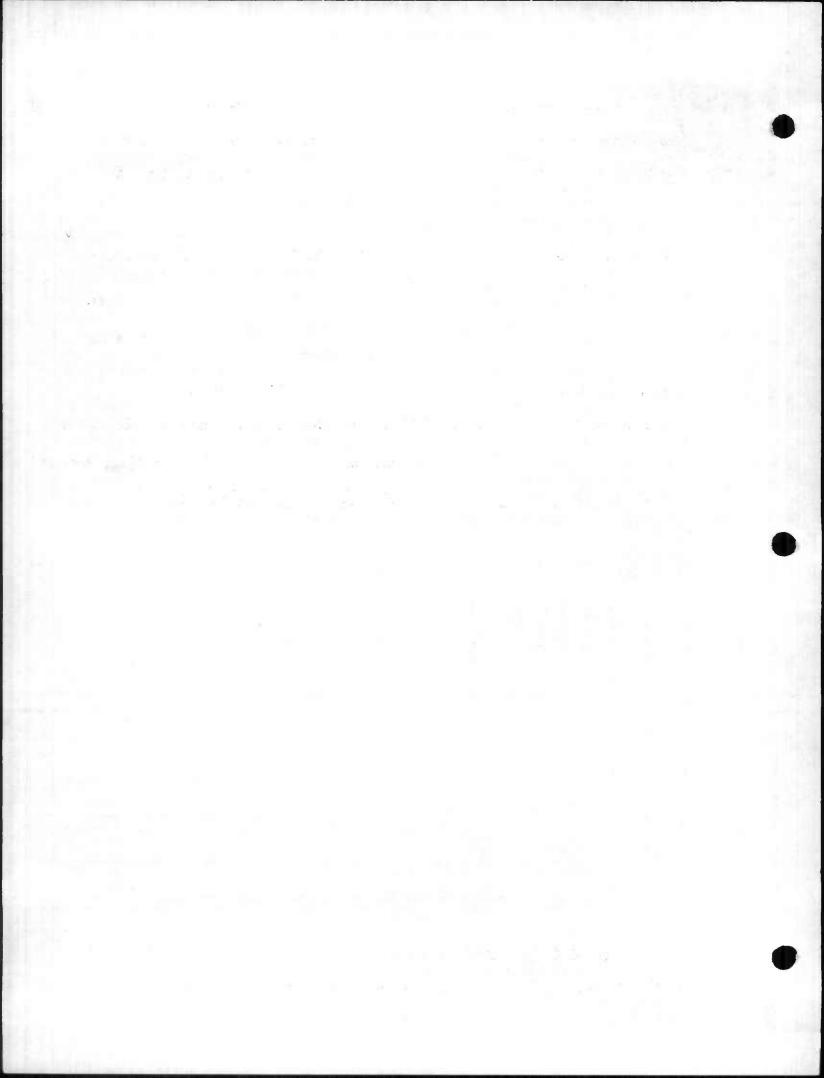
January 13, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Martin S. Rosenthal, M.D., 10810 Connecticut Avenue, Kensington, Maryland 31. Date filed (Month, Dey, Year)

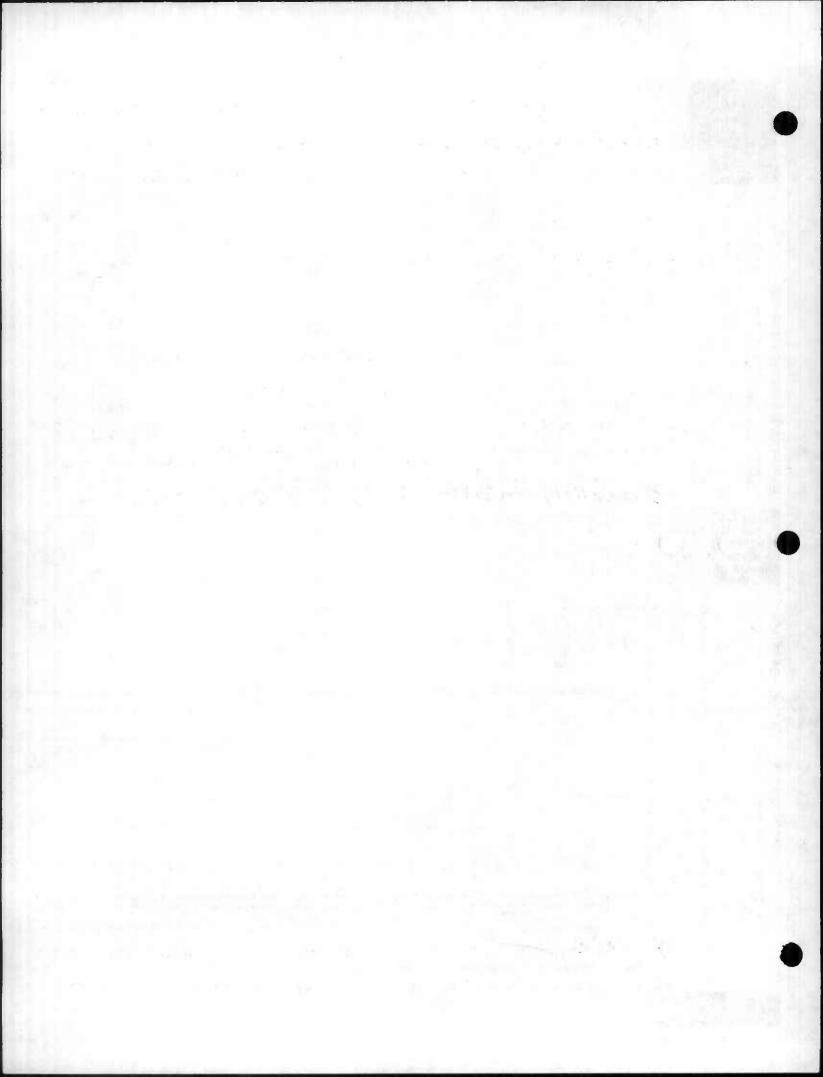
State Registrar

32. Registrer's Signeture hia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, La	st)			f Death	2. Dete of D	Reg. No.		3. Time of De
Physici		Jorge Alberto	Paz				Month Janua	Dey ry 12, 1	Yeer	
/Medic		4e. Fecility Neme (If not institution, give				4b. City, Town, or				10:20 I
L AGIIII	ICI	12125 Village Sc		00 #301						
uneral		5. Social Security Number 6. S		(In yrs. lest birthda	If Under 1 Yea	Rockvi	s. 8. Dete of B (Month, D		ntgom 9 Birthole	
irector		578-04-5950 Usuel Residence of Decedent	№ 2□ F	63 Yrs.	Months Dey	s Hours Min	Februar	y 13, 1934		ece (State or Fory) Lnidad
show	L.	10e. State 10b. County		10c. City, Town or	Location				10	d. Inside City L
23s or 28s-1 show	ecto	Maryland Montgon	ery	Rocky						1 Tes 2
De D	Ö	10e. Street end Number			10f. Zip Code		17.	10g. Citizen of W	/het Countr	ry?
18 23	era	12125 Village So	uare Terra			852	2 11 - 11		duras	
al', or items Examiner m	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forces? 1 Tyes 2 No. 1 Yes, Give Year or Dates:		If Yes, specify Cu		ondurans	Specify.	e - America k, White, et : : Whit	tc.
	ted	15. Decedent's Ed	ducation	16a. Dec	cedent's Usuel Occ	unetion		16b. Kind of Bu		
item 27 is marked other than "natur other traumatic event, the Medica	Completed	(Specify only highest green Elementary/Secondery (0-12)	College (1-4or 5-	life	DO NOT use reti	ne during most of wo	orking			
E E	S	12		Ger	neral Cle	aner		Count	ry Cl	ub
is marked other than sumatic event, tre M	Be	17. Father's Neme (First, Middle, Last,				18. Mother's Ne	me (First, Middle	, Melden Surnem	Ð)	
narka vatic	2	Alberto Paz					ia Pasc			
raun Traun		19a. Informent's Name/Reletionship (et end Number or R				
Important: If item 27 I any injury or other tra once.		Jose Gilberto Paz 20e. Method of Disposition	/son	20h Plece of Dis	West 461	th Street	, #406,	Hialeah,	Flor	cida 33
I I I		1 X Burial 2 Cremation 3		cemetery, cr	remetory or other p	January	17,1998			
Important: If it any injury or c	-	4 ☐ Donetton 5 ☐ Other (Specification 21. Signeture of Funerel Service Ligar		Cementer	10 Gener	al		San Pedro	Sula,	Honduras
lmpo any ir once.		Barbara Jo Mon	JulkyJan	hence !	300 West Mon	umphrey Fundation	enue, Rock	wille, Mar	, Inc.	20850-2
OR THE		23a. Part1. Enter the diseese or com shock, or heart fallure. List only	olicetions thet caused tone cause on each line	he death. Do not e	inter the mode of d	ying, such es cardie	c or respiretory	errest,		Approximate ntervel Between
sician edical miner		Immediate Ceuse (Finel diseese or condition resulting In death)	e Congest	ive Heart	: Failure					Onset end Deat
	5	rooding in doubly		ue to (or es e cons	equence of):					
nsit	Examiner		D	c Heart D						
physician and s the burial-transit	Xa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	ue to (or es e cons	equence of):					
por I		Cause (Disease or Injury that initiated events	0.		Infarct	ion				
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attending for usa a		resulting in deeth) Lest	d	not resulting In the	underiving cause of	iven in Part I	23h Did	tohacco use con	Inhute to t	he cause of de
attending for usa a		Pert II. Other significant conditions of	d	not resulting In the	underlying cause ç	given in Part I.		tobacco use con		
attending for usa a	Physician/M	resulting in deeth) Lest	d	not resulting In the	underlying cause g	jiven In Part I.		tobacco use con Yes 2□ No		
igned by the attending be detached for usa a	by Physician/M	Pert II. Other significant conditions of	dontributing to death but	not resulting In the	underlying cause g	given In Part I.	1 🗆	Yes 2□ No	3 Proba	ably 4∑Unk
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has been signed by the attending ge 2 should be detached for usa a	by Physician/M	Pert II. Other significant conditions of	d	not resulting In the	underlying cause g	jiven in Part I.	1 🗆 24e. Wes	Yes 2□ No	24b. Were eveil compof de	e eutopsy findir eble prior to pletion of cause
has been signed by the attending ge 2 should be detached for usa a	Physician/M	Pert II. Other elgnificant conditions of Hyperlipidemia		not resulting In the	underlying cause g		1 🗆 24e. Wes	Yes 2□ No en eutopsy ormed? Yes 2☒No	24b. Were eveil compof de	e eutopsy findir eble prior to pletion of cause eath?
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ctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for usa a	To Be Completed by Physician/M	Pert II. Other eignificant conditions of Hyperlipidemia 15. Wes case referred to medical examiner? 117 Yes 2 D No 17. Menner of Deeth 16. Neturel 5 D Pending	Hospitel: 1 ☐ Inpatient 28e. Dete of Injury (Month, Dey	2 ER/Outpatit 28b. Time Injury (- At home, farm, s	ent 3 DOA Of 28c. Inj	26. Place of De ther: 4□ Nursing H ury et ork? □ Yes 2□ No	24e. Wesperfind 1 Deth (Check only Home 5 X Res 28d. Describe 28f, Location (Yes 2 □ No sen eutopsy primed? Yes 2 □ No one) dence 6 □Othe	3 Proba 24b. Were evelicomm of de 1 ' ' ' (Specify) ed	e eutopsy findir eble prior to pletion of cause sath?
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ctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for usa a	Medical Certification: To Be Completed by Physician/M	Pert II. Other eignificant conditions of Hyperlipidemia Hyperlipidemia 25. Wes case referred to medical examiner? 1 Nes 2 No 27. Menner of Deeth 1 Neturel 5 Pending Investigation 1 Neturel 5 Neturel 1 Ne	Hospitel: 28e. Dete of Injury (Month, Dey 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. 28e. Place of Injury (Month, Dey 2006) 28e. Place of Injury (Month, Dey 2006) 28e. Place of Injury (Month, Dey 200	2 ER/Outpation 28b. Time Injury (- At home, farm, some semination end/or indicate) The property of the semination end/or indicat	ent 3 DOA Confidence of the courred et the convestigation, in my 29c. Licer	26. Place of De ther: ury et ork? Yes 2 No ime, dete end plece opinion, deeth occu	24e. West performent of the Check only Home 5 X Res 28d. Describe 28f. Location (City or To	Yes 2 □ No sen eutopsy primed? Yes 2 ☒ No one) dence 6 □ Othe how Injury occurre Street end Number win, Stete) ceuse(s) end mer dete and plece, en	3 Proba 24b. Were evelicomy of de 1 '' r (Specify) ed or or Rural F	e eutopsy findir eble prior to pletion of cause ath? Yes 2 No Route Number, ted. he cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 40 County of Death Examiner 5. Social Security Number (In yrs. last birthday) 81 Yrs. If Under 24 Hrs. 1 Year 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 578-20-1419 Months Days 1 M 2 F Yrs. Director AUG. 15, 1916 SOUTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r than "naturel", or items 23a or 28a-f show the Mexical Example; must be notified at 10d. Inside City Limits Director N/A N/A WASHINGTON, DC 1 TYes 2 No 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Counfry? 900 G. STREET N.E. APT. 427 20002 U.S.A. Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 22No If Yes, Give Year or Dafes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK by Specify: 3 → Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ges 1 end 2 should be filed within tt of Health and Mental Hygiene. If Item 27 Is marked other than College (1-4or 5+) Elementery/Secondary (0-12) 12 DOMESTIC PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be SIMON HAMPTON ETHEL WILSON HAMPTON COATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3403 ACCOLADE DR., SANDRA S. MC DANIEL CLINTON MD 20735 other 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) HUNTT CREMATORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. 0 1/16/98 WALDORF, MD 4 Donation 5 Other (Specify) 21. Signature of Edneral Service Licitation 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON 3439 LIVINGSTON ROAD 20640 INDIAN HEAD, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner AFRONIC OBSTRUCTIVE LUNG DISCHOT Examiner The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and physician Physician/Medical the Due to (or as a consequence of): as ettending p Part II. Other algnificant conditions confributing to death buf not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t KENAL 1 Yes 2 No 3 Probably 4 Unknown ps A should should 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? cate has t this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth. To the Funerel Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatienf 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury ef Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide

State Registrar

Medical

29a. Certifier

ASAR

31. Date filed (Month, Day, Year) JAN 1 5 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature and fifle of certifier

7501 SUPPLATES 32. Registrar's Signeture Ali Skoolson Revolate

0 M.

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the fime, dete and placa, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated.

29c. License number

Road, SUITE 208B, CLINTON MD 20735

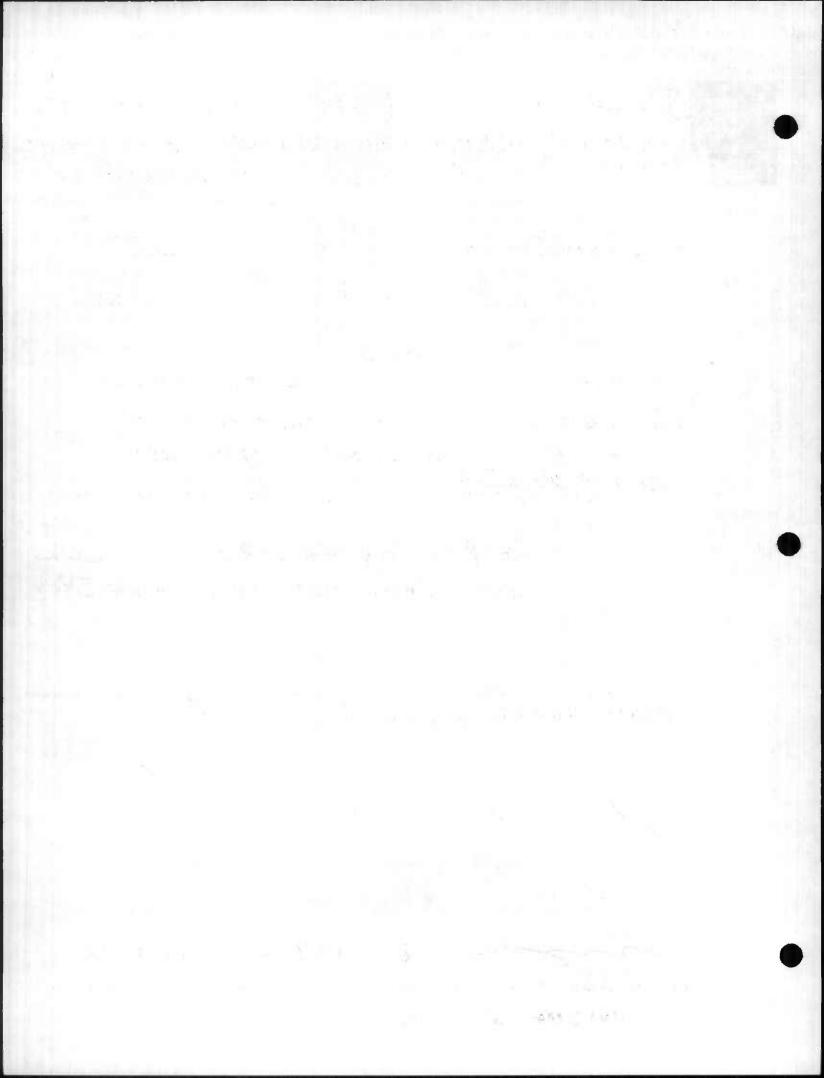
Baltimore, Maryland 21215-0020

Box 68760,

P.O. I

Records,

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month DALMAS JAMES PARKER 12 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 8/9/13 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 216-09-8882 84 YES Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maoical Examiner must be not fed at Director 1 ☐ Yes 2 X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with Department of Health and Mentel Hygiene. Important: if item 21 is merked other than "natural", or items 23a or any Injury or other traumatic event. 6618 South Point RD 21811 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Ves 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic OrlgIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: py Specify: WWII 3 Widowed 4 □ Divorced white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Gas Station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samson E. Parker Mamie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol P. Rose/ Daughter 6618 South Point RD Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/98 Sunset Memorial Park Berlin, MD 5 Other (Specify) 21. Signar per of Finneral Service Ocean 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 e 1. Enter y e di se, or implications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shick, or he in failure. List only one cluse on each line. **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ ARKER, 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturel efter death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1112 98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HeziThwy

JAN 1 2 1998

9733

Drive

32. Register's Signature

Berlin, MD

DHMH 16 Rev 6/95

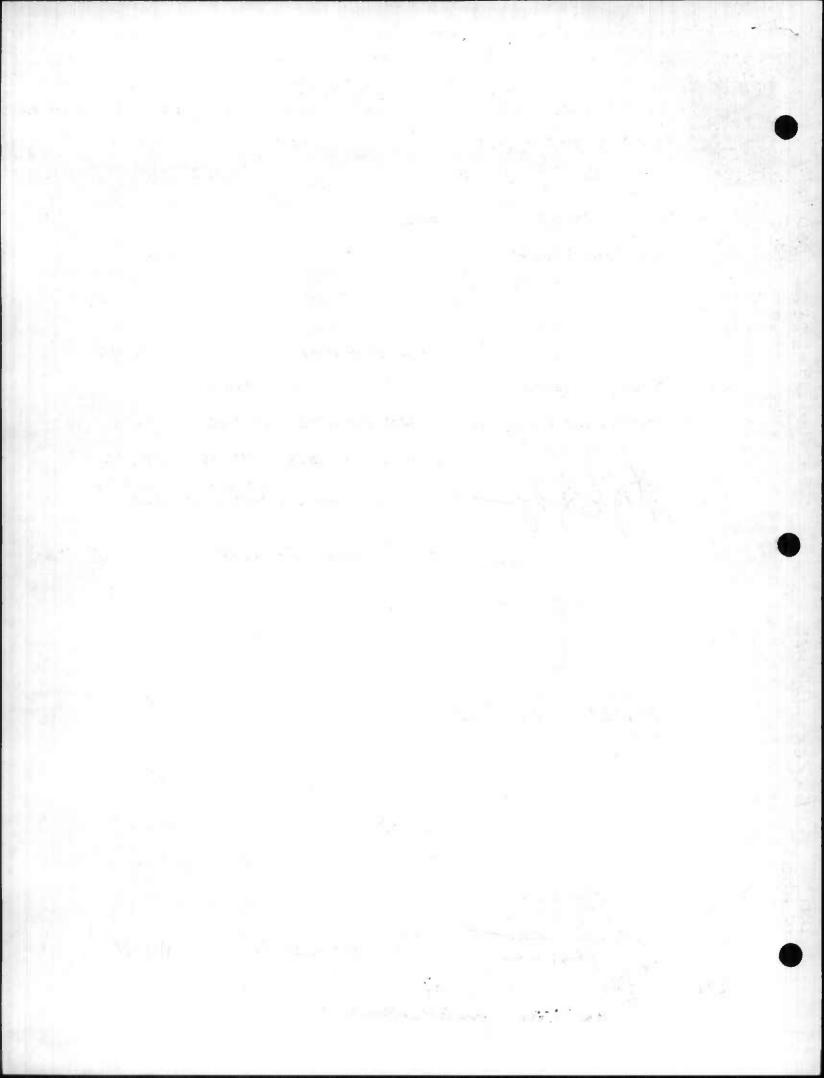
State

Registrar

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S# 016-09



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Month January 8, John E. Pearson 1998 1:20 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Yeer | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | September 6. Sex 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foraign Country) WISCONSIN 7. Age (In yrs. last birthday) 389-12-5848 77 Yrs. 1920 Usual Rasidence of Decedent 10a, Stete 10b. Count 10c. City, Town or Location 10d. Insida City Limits YOYAS 2 No Prince George's Maryland Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5821 Queens Chapel Road 20782 United States 12. Was Dacedant Evar in U,S. Armed Forces? WW I I 1 ∑ Yas 2 ☐ No If Yes, Give Yaer or Datas: Korean Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yes 2 No Specify: specify: White 3 Widowed 4 Divorced 18a. Decedant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Department of Coilega (1-4or 5+) Eiamentary/Secondary (0-12) Defense Linquist 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Otto Pearson Mildred McNeil 19e. Informent's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lavinia M. Bowen (daughter) 7829 Marioak Drive, Elkridge, Maryland 21075 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Crametion 3 ☐ Ramoval from State 1-9-98 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory Beltsville, Maryland 22. Nama and Address of Feolity
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 21. Signatura of Funarai Sarvice Licensee 20910 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intarvai Between Onsat and Death Immediata Causa (Final Chronic Obstructive Pulmonary Disease 20 years diseese or condition rasulting in death) Dua to (or as a consaquance of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avellabla prior to complation of causa of death? 24a. Was an autopsy performed? 1□ Yas 2 No 1 Yas 2 No 25. Was casa ratarrad to medical 26. Piece of Daath (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Deeth 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itama 23a or 28a-f ahow the Mexical Examiner must be notified at

Director

Funeral

à

Completed

Be

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72 hours after

flied within 7 Hygiana.

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othe any injury or other traumatic avant.

other

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be 10 Certification:

1 Naturai

2 Accidant

4 Homicida

29b. Signature and title of certific

3 Suicida

29a. Certifiar

5 Pending

investigation

6 Could not be

physician and s the burial-transit The law requires that the death cartificate be executed attanding p been signed by the should be datached paga 2 this cartificata

Box 68760. To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director.

P.0. Records, Division of Vital

> State Registrar

Medical

Scott Joslin, M.D. 9210 Corporate Blvd., Rockville, Maryland 31. Data filed (Month Day, Year) 32, Ragistrar's Signatura

30. Nama and address of parson who complated causa of daath (Itam 23a) (Type, Print)

us Savidson

28b. Time of

28a. Piaca of injury - At home, farm, streat, fectory, office building, atc. (Specify)

28c. injury at Work?

Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data end place, and dua to tha cause(s) and mannar as stated.

 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data end place, and dua to the cause(s) and menner stated.

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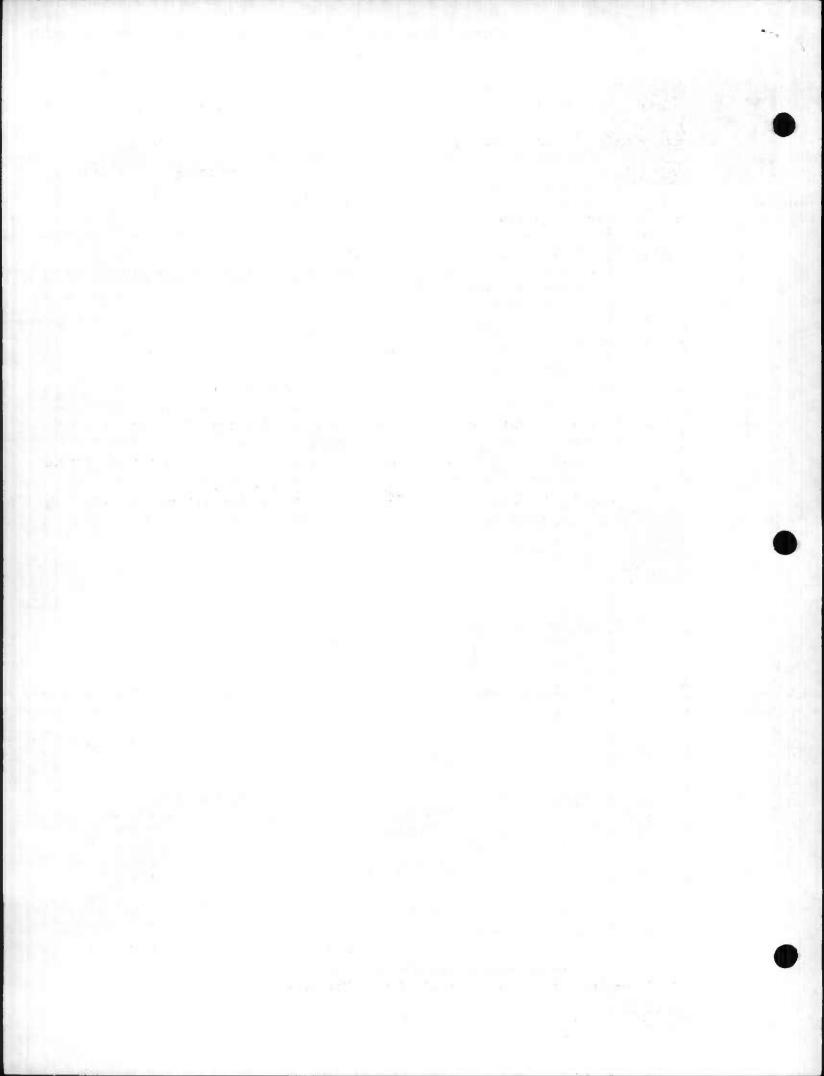
29c. Licansa number

1 Yas 2 No

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

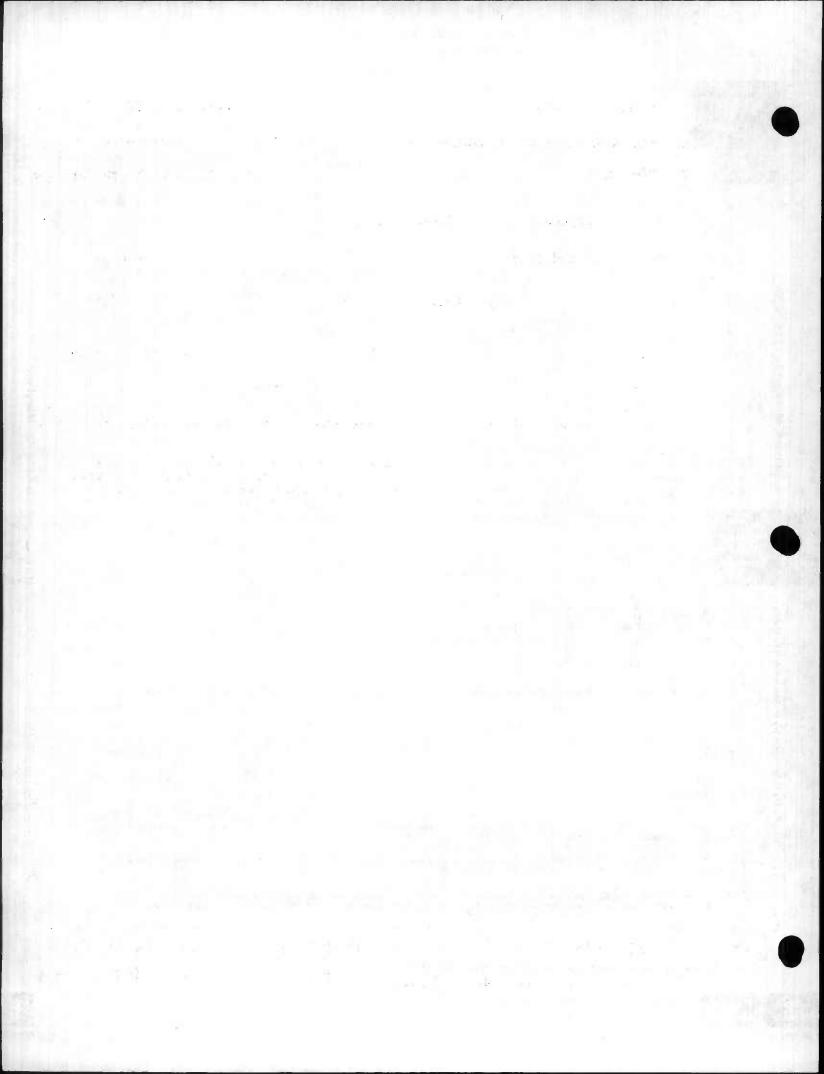
29d. Data signed (Month, Day, Year)

January 8, 1998



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Neme (First, Middle, Li	ast)		Certific	cate of	Death	2. Date of De	Reg. No.) U	3. Time of D
Physic		Raymond L. Pee	ele					January	11, 19	98 ^{Veer}	5:05
/Medi Exami		4a. Fecility Neme (If not institution, gi		r)			4b. City, Town, or	Location of Death	- 1	v of Deeth	
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uneral		5. Sociei Security Number 6.	Sex 7. A	age (In yrs. last bi	rthdey) If U	Inder 1 Year	if Under 24 Hrs	s. 8. Date of Birt	_		ece (State or F
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12	to	MD Montgon	nerv	Silve	er Spr	ine					1 ☐ Yes 2
r 284	Director	10e. Street end Number				f. Zip Code			10g. Citizen of	Whet Count	rv?
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"naturel", or items 23a or 28a-f show edical Examiner must be notified at	by	1 ☐ Never Married 2 【3 Married 3 ☐ Widowed 4 ☐ Divorcad	Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Detes	No UTUIT T		specify Cube es 2🖾 No	Specify:	rto Rican, etc.)	Specia	ick, White, e fy: Whi	
	ted	15. Decedent's E	ducation	16e	Decedent's	Usual Occup	etion		16b. Kind of B	lusiness/Indu	ustry
	Completed	(Specify only highest grant (0-12)	College (1-4or	5+)	life. DO NO	or work done OT use retired	during most of wa	orking			
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	2	Raymond Peele					Mary Ly	on			
S E E		19e. Informant's Name/Reletionship (Type, Print)	19b	. Mailing Add	iress (Street	end Number or A	lural Route Numbe	r, City or Town	, Stete, Zip (Code)
item 27 i other tr		Mildred S. Peele	(wife)					ve, Silv	er Spri	ng, M	D 2090
f ite		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐	Removed from State	20b. Plece o cemete	f Disposition ry, cremetory	(Neme of or other plea	ce)	Dete	20c. Location	- City or Tow	m, Stete
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To the Funeral Director: After this completely filled in by the funeral di		27. Menner of Deeth 12 Naturel 5 Pending 2 Accident investigation		ury 28b. T	ime of njury M	28c. Injun Worl		28d. Describe h			
el Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, e	jury - At home, fe c. <i>(Specify)</i>				28f. Location (S City or Tow	n, State)		
To the Funeral Dire	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the besis of and menner si	or exeminetion end	, deeth occur d/or investige	red et the tim tion, in my op	e, dete end plece plnion, deeth occu	a, end due to the curred et the time, c	euse(s) end mo ete end pleca,	enner as ster	ted. he ceuse(s)
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41	-	30. Neme end eddress of person who	t-t-d	1	T 5					1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear 9,1998 Catherine Harris Pfister JANJAM 3 pm 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2□ F Days Yrs 142-18-3962 90 Jan. 10, 1907 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12819 Matey Road 20906 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorcad White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Dean Harris Harriett Lovinia Bower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Hayes (daughter) 4907 Carriage Park Road, Fairfax, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/09/98 Alexandria, VA 21. Signature of Funeral Service Utera Francis J. Collins Funeral 22. Name and Address of Facility Home, Inc. 500 University Blvd. West Sober Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause off each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONEW MONIA 2044 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CATRONIC PUMDIATER PUEDOS 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 TYPS 2 NO 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner attanding physician and for use as the bunal-transit The law requires that the death certificate be executed Box 68760, Physician/Medicai P.O. signed by t Records, þ Completed page 2 certificate Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

must be notified at

"natural", or Items 23s

permit. Pages 1 and 2 should be tited w Department of Health and Mental Hygien important; if tem 27 is marked other tha any injury or other tree

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director.

10

State Registrar

edical

4 Homicide

29b. Signature and title of certifier

29a. Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)

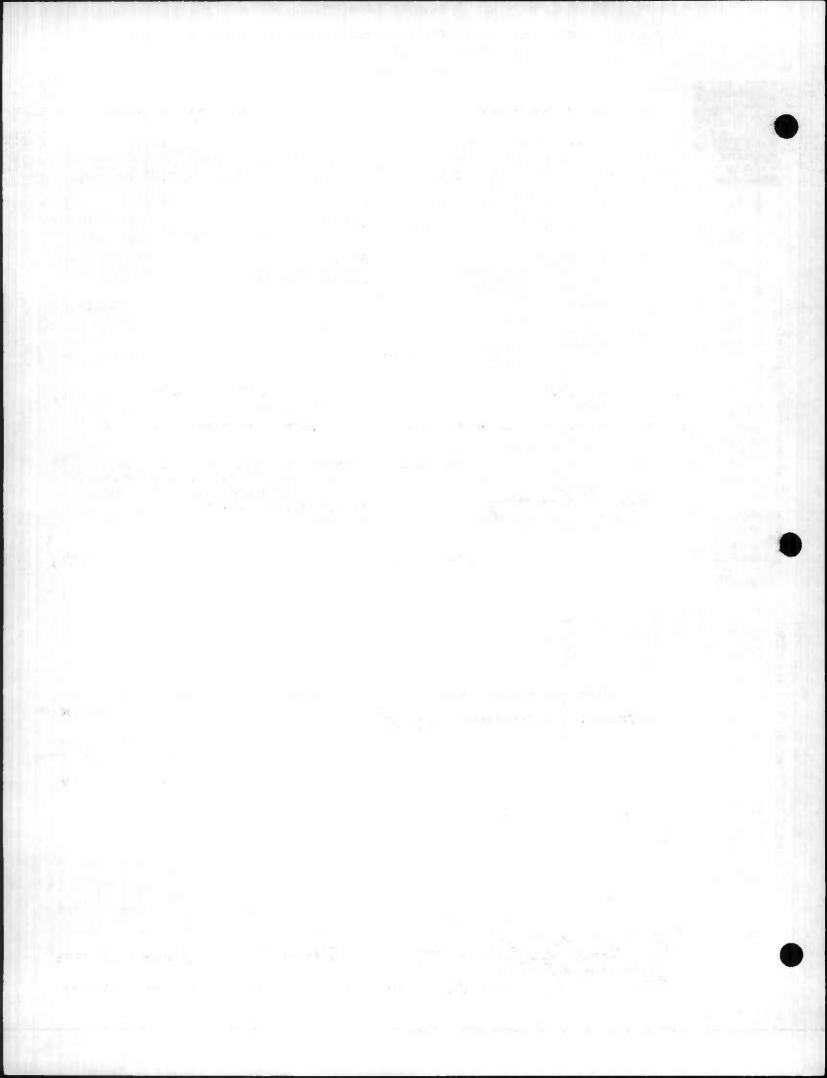
JAnuary 9,1998

30. Name and eddress of per pleted cause of death (Item 23a) (Type, Print)

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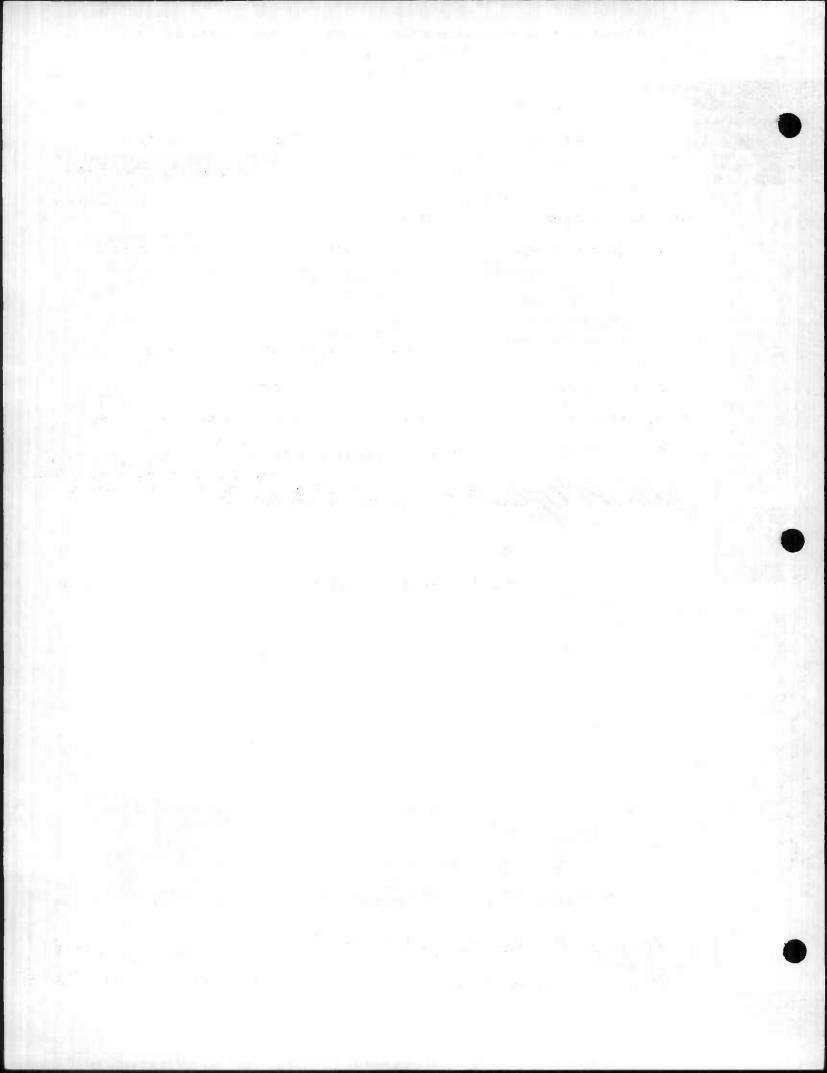
5540 TEN DAYS EN CHARKSVINE, UM LIDES m 32, Registrar's Signature

31. Date filed (Month, DAN Year) Sa Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene

						Ce	ertifica	te of	Death		Reg. No.	3 0	1952	>
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	land land		10e. Stete 10b. County		10c. Ci	ity, Town or I	Location					1	Od. Inside City	Limits
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Saltimore, Maryland 21215-0020	permit. Pages 1 Department of the Important: If ite any injury or ot once.		21. Signature of Fugeral Service Lice	// "	M00092	R	ockvi	11e,	ess of Fecility Rob Inc. 300	West N	Pumphre Montgome	y Fun	neral Ho	
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13	To the Hospital within 24 hours e To the Funerel Completely filled	edical	29a. Certifier (Check only one) 1 CertifyIng Pl	nysician: To the bearing of the basis and manner	of exemine	owledge, dee etion end/or l	th occurred	d et fhe ti n, In my d	me, date end pleca, opinion, deeth occur	end due to the red et the time,	ceuse(s) end m date end plece,	enner es st , end due to	eted. the ceuse(s)	
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			Milliam F	finu	and	A, MI	D,	D365	520		Care.	n 7	1998	>
	20		30. Neme end eddress of person who				e, Print)				an with	0	,,,,,	
			William F.			MD	; De	pt, r	1 edical E	ducati	un, Sul	ourbi	m Itos)	pital
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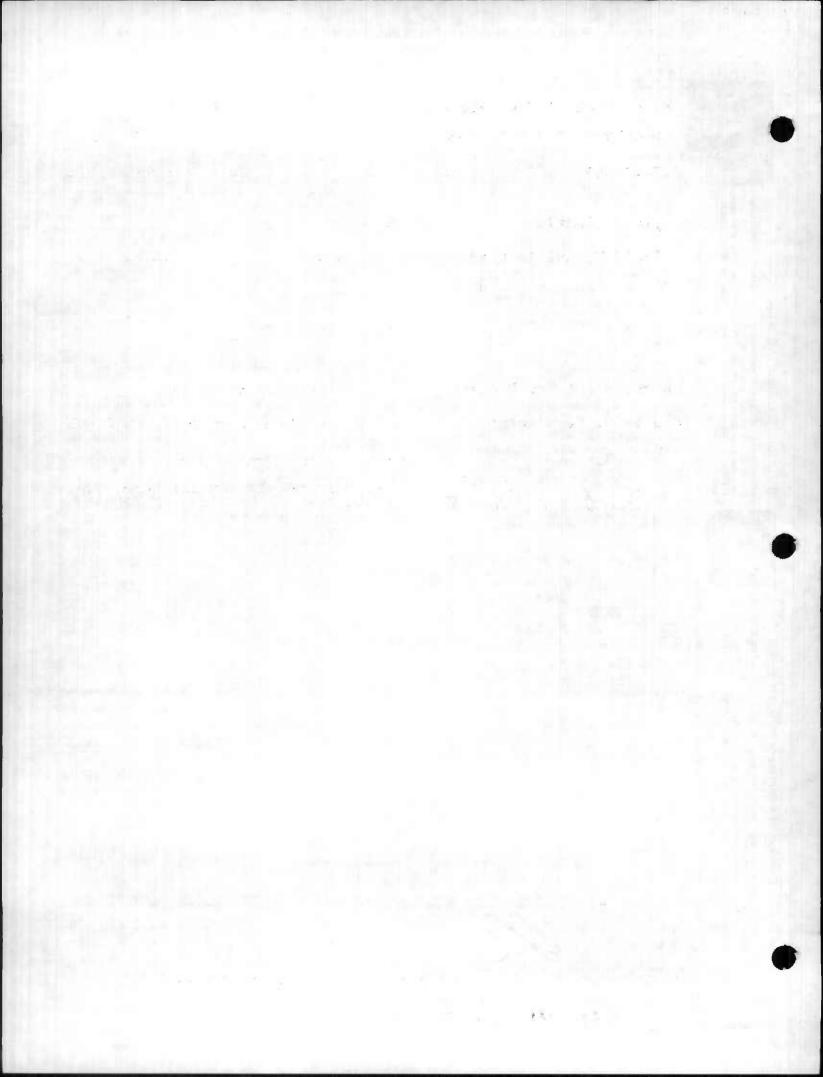


State of Maryland / Department of Health and Mental Hygiene KYLE SAMS Reg. No. 9 Certificate of Death Items: 23a part I,27 per MEO G-755 1/29/98 dh 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth Month **Physician** Kyle JANUARY 07, 1998 Michael Sams Pickeral 5:57PM /Medical 4c. County of Death CHARLES 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath Examiner PHYSICIAN'S MEMORIAL HOSPITAL LaPLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year)
July 17, 1996
Maryland 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1 M 2□ F 1 Yrs. 217-47-6957 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Charles Waldorf Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14652 Woodville Road U.S.A. 20601 2 should be filed within 72 hours efter death and Mental Hygiene. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yas, Give Year or Dates: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify hite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Richard Antoine Pickeral Connie Marie Sams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other treum once. Connie M. Sams/mother 14652 Woodville Rd. Waldorf, MD 20601 Baltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Church Cem. 1/12/98 Bryantown, MD 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility M00817 Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646 P.O. Box 567 La Plata,
23a. Part1. Enter II. disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician Immediate Cause (Final disaasa or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be execu Box 68760 Physician/Medicai Due to (or as a consequence of) 88 US6 for 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached the signed by t 1 Tyes 2 No 3 Probably 4 ≥ Unknown þ Records, 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of ceuse of deeth? page 2 certificate has 1 PYas 2 □ No 1 2 Yes 2 □ No Division of Vital Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death Certification: To After this 28a. Date of Injury (Month, Dey Year) uneral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural deeth. 1 Yes 2 No 2 Accident efter deeth the 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meneer stated. To the F within 2 To the F 29c. Licensa number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certified O.C.M.E. JANUARY 08, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 David Fowler, M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signature

Registrar

JAN12

Lin Danielson Rardall



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Miguel A. Perez Polanco 7, 1998 January 7:55 PM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 7931 Mandan Road, #104 Greenbelt Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□ F Months Deys Hours Yrs. 96 Director 212-33-1088 Sept. 29,1901 Chile Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 X Yes 2 No Director Maryland Prince George's Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7931 Mandan Road, #104 20770 Chile Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 N Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Chilean Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4 Accountant Banking permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy important: If feen 27 is marked other any injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Froilan Perez 2 Alejandrina Polanco 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marta P. Mangum/Daughter 7931 Mandan Road, #104, Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 9, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funerel Service Licens 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc/7557 Wisconsin Avenue, M00672 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel Acute Myocardial Infarction disease or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): ettending physician for use as the burie 2 Physician/Medical Due to (or as a consequence of): ed by the e Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peen page 2 hes 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician; efter death.

Director: After this certifica 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 X Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending 1 X Naturel 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital
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State Registrar

Don H. Yablonowitz, M.D., 7404 Executive Place, #502, Seabrook, Maryland 20706 32 Registrer's Signeture is Davidson

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

31. Dete filed (Month, Day, Year) JAN 12 1998

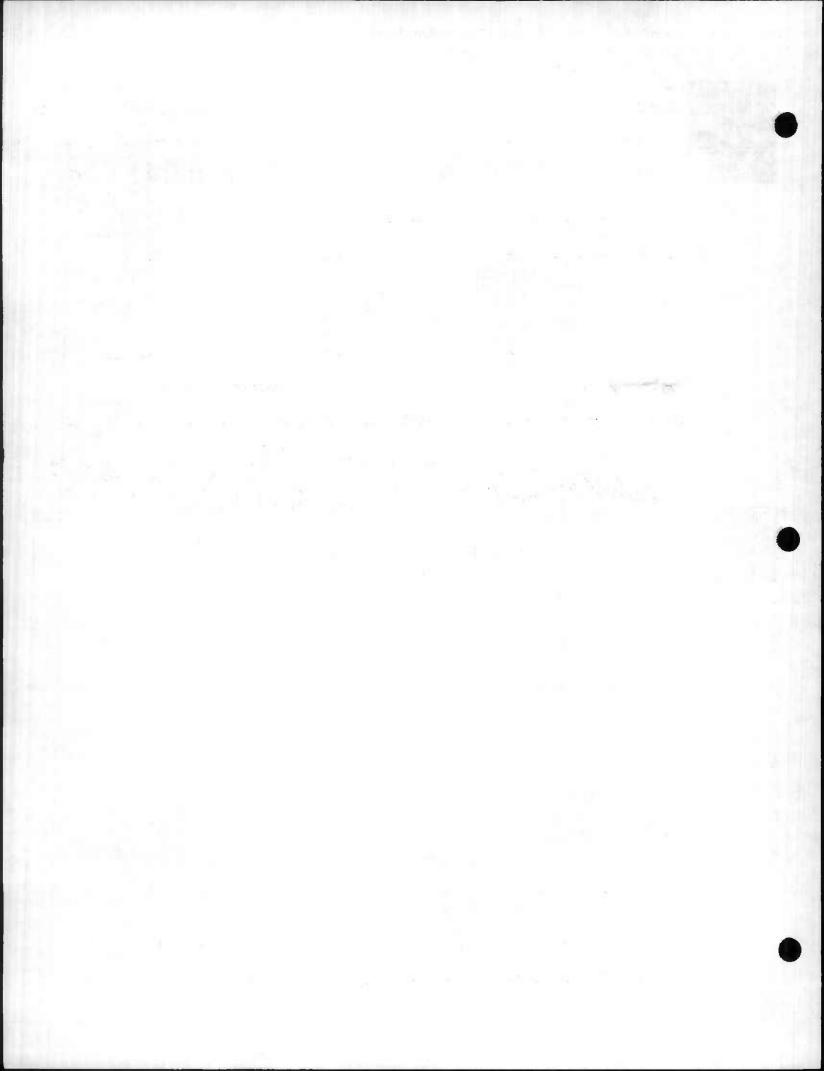
Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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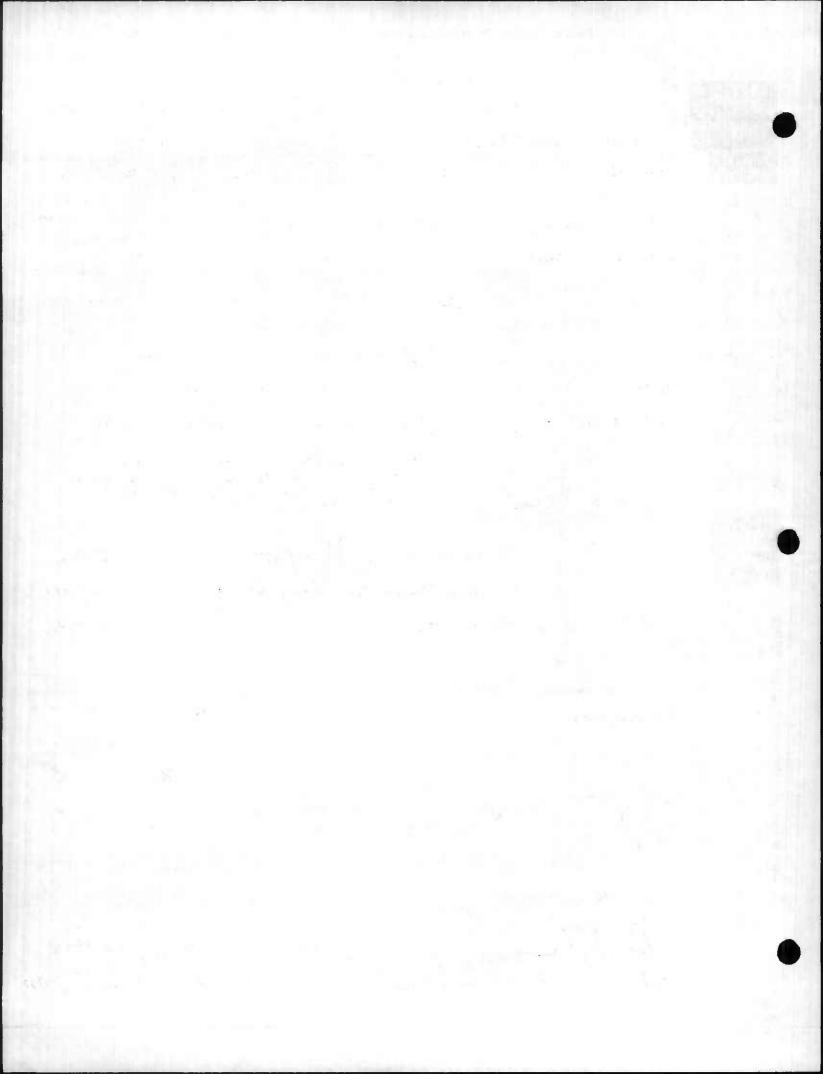
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State of Maryland / Department of Health and Mental Hygiene 98 0 956

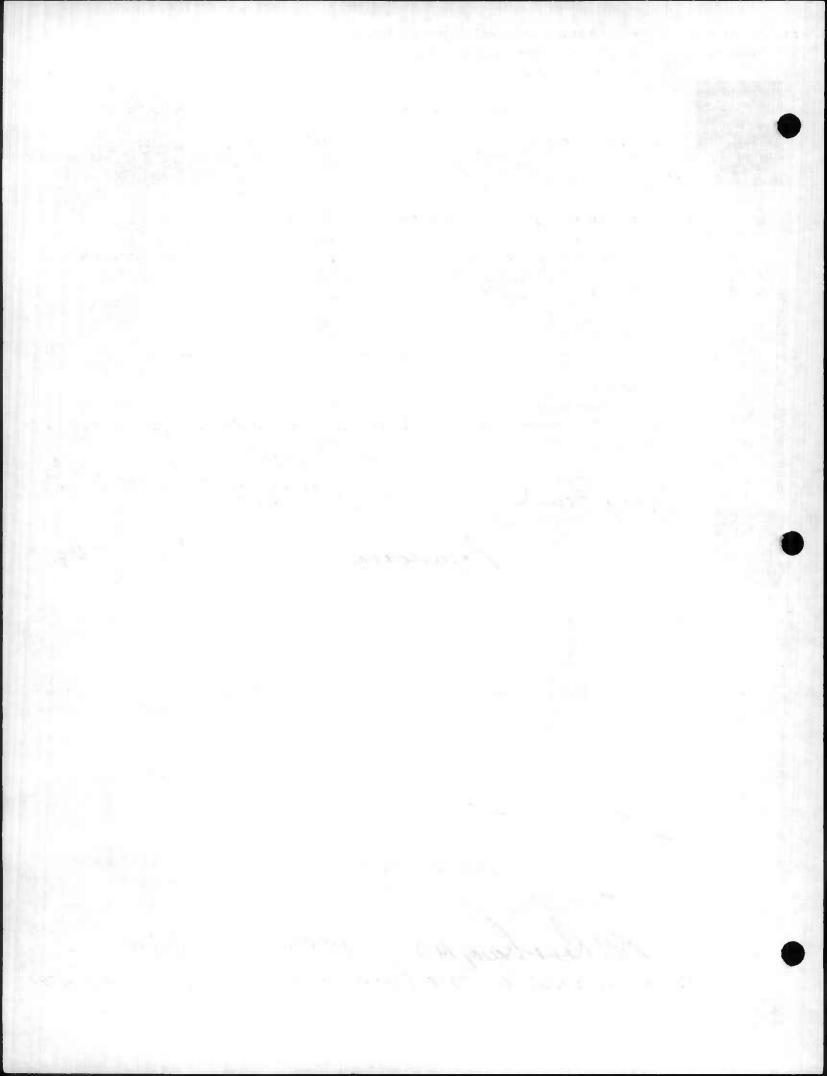
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Examin		4e. Fecility Neme (If not Institution, gh	a street end number,)				4b. City, Tov		ation of Death		of Daeth	
	П	Holy Cross Hosp	oital					Silve	r Spr	ing	Mont	gomen	СУ
Funeral Director		5. Sociel Security Number 6. S 094-34-0095 · Usuel Residence of Decedent	Sex 7. A(ge (In yrs. les 84	t birthday) Yrs.	If Undar Months	1 Year Deys	If Under 2 Hours	Min.	8. Date of Birt (Month, De July 19	, Yeer) , 1913	Cour	olece (Stete or Fo otry) Land
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or 28	ire	10e. Street end Number				10f. Zip	Code				10g. Citizen of	Whet Cour	ntry?
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or items	by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Yaar or Detes:	?		Was Deced If Yas, spe-		lispenic Ortg en, Mexicen Specify:	in? (Spec , Puarto R	ify Yas or No- icen, etc.)	14. Red Blee Specify	ce - Americ ck, White,	
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Is mar	-	19e. Informant's Neme/Relationship (Type, Print)		19b. Mailin	na Address	(Street		-		r, City or Town,	Stete. Zin	Code)
ith a		Leonard J. Prosso	r/Husband										1D 20895
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2:06 P.m JAN. 10, 1998 BOBBIE F. RAGLAND 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY Burtonsivlle 3720 Angelton Court 8. Dete of Birth (Month, Dey, Year) Oct. 24, 1927 9. Birthplace (State or Foreign Country) Alabama 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Yeer 6. Sex Months 1 X M 2 ☐ F Deys 421-26-5535 Yrs. 70 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Burtonsville Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20866 U.S.A. 3720 Angelton Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ᠌ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Specify: Black 1 Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New Zealand Elementary/Secondary (0-12) Coilege (1-4or 5+) Maintenance Engineer 12th Embassy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Smith Ragland Lucy Phillips 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20866 19a. Informant's Name/Relationship (Type, Print) 3720 Angelton Ct., Burtonsville, MD Valerie Ragland-Bland (Dau.) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cametery, cremetory or other place) 1 Duriai 2 Cremation 3 Removal from State Gate of Heaven Cem. 1/16/98 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Usense SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD Approximete Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1/2 Live metastate Canca Due to (or as a consequence of) Cance Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy 28 No 1 Yes 1 TYes 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Yeer) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

attending physician and for use es the buriel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a signed to been si hes le 2 r this certificate hes arel director, page 2

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Examiner

Funeral

Director

r than "natural", or liems 23a or 28a-f show the Medical Examiner must be notified at

72 hours after

filed within

8 and Mental

permit. Pages 1 and 2 should be Department of Health and Menta Important. If Item 27 is marked any injury or other traumatic ex

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice etely filled in by the funeral director, I in 24 hour. the Funeral Directory filled in

Physician/Medical by Completed Be 2 Certification:

edical

1 Naturai

2 Accident 3 Suicide

4 \ Homicide

29e. Certifier

State Registrar

To the comple To the

29b. Signature and the of certifier STEVEN A BURGER, MO

6 Could not be

29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

021931

1 Yes 2 No

SILVER SPRING, MD

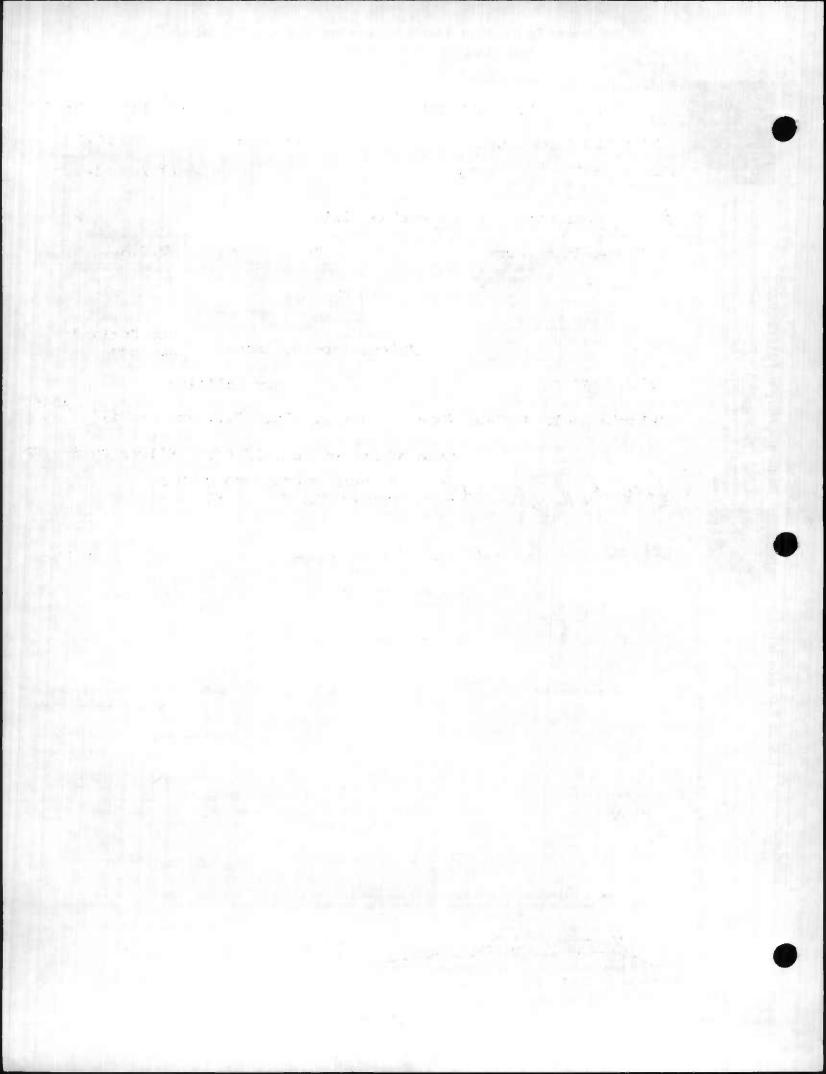
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

2101 MEDICAL PARK DR

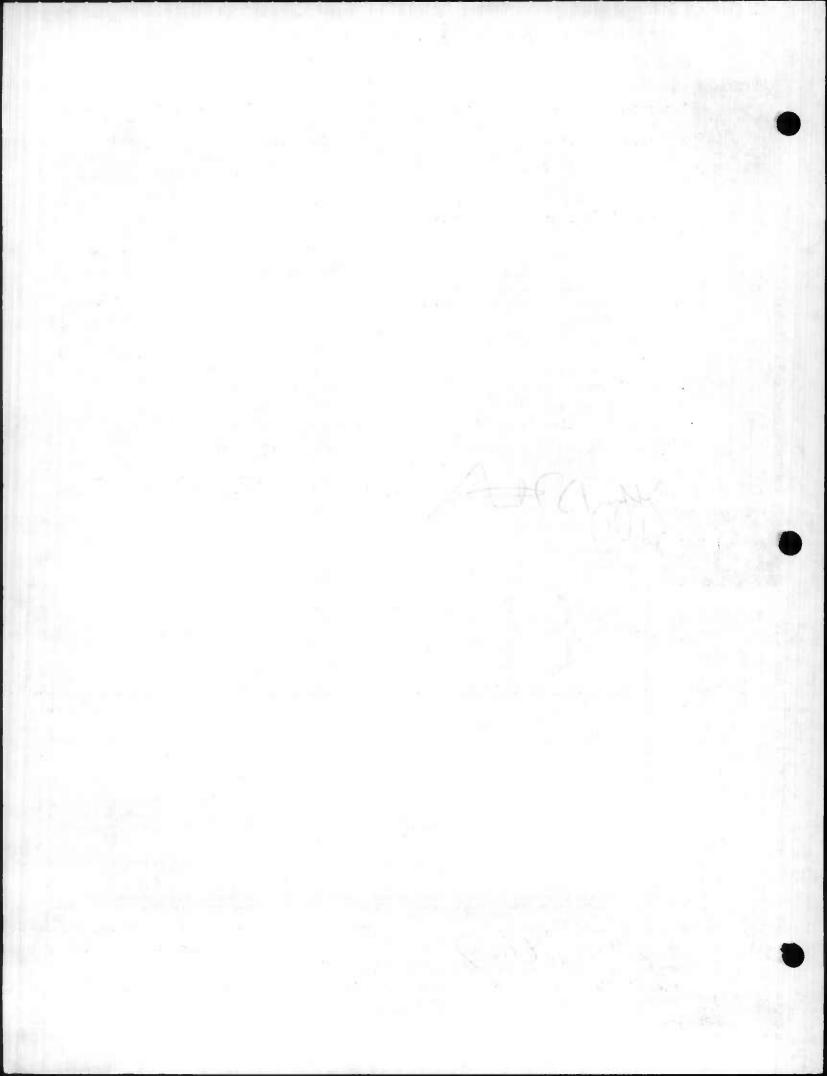
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signeture whe Davidson-Aandell

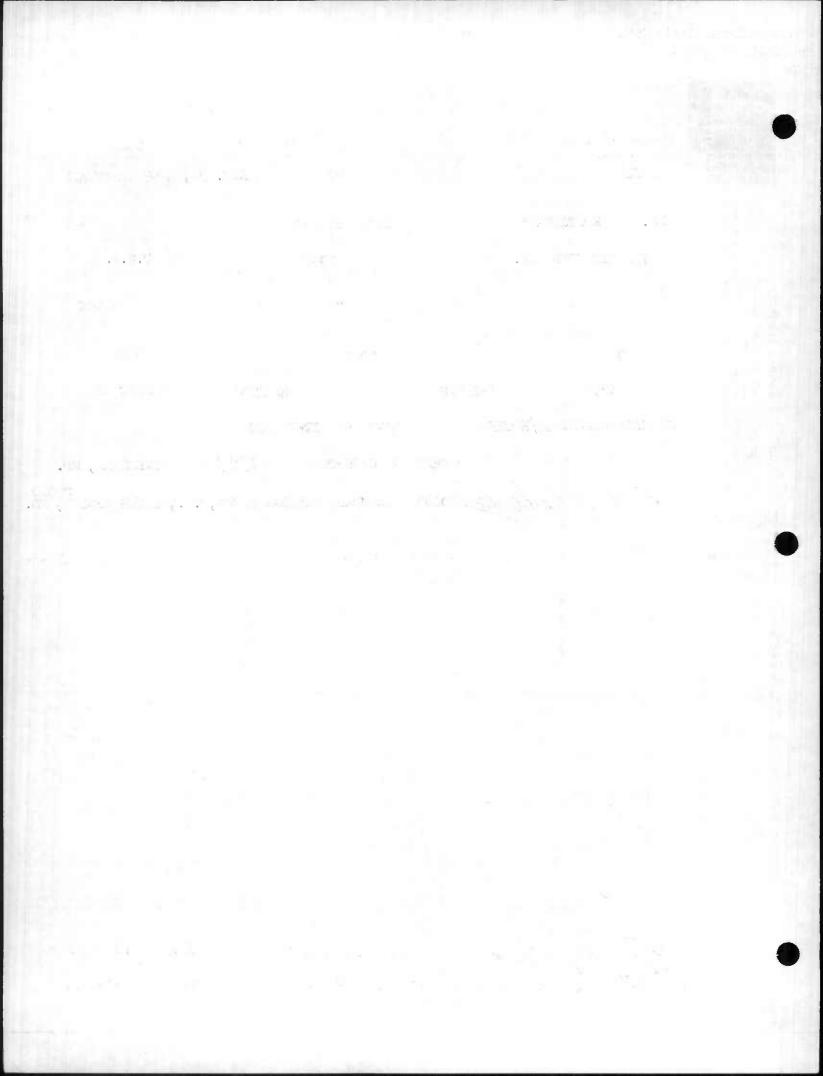


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medic		4e. Fecility Neme (If not inst							4b. City, Town, or L				200	33 111
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uneral		5. Sociel Security Number	6. Se			lest birthday) Yrs.	If Under Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da)	h y, Year)	9. Birthpl Count	lece (Stetry)	ate or Foreign
irector		505-03-5137 Usuel Residence of Decede	nt		79					Sept. 1	3,1918	Nebra	ıska	
MOI!		10a. State 10b. Co			10c. C	ity, Town or Lo	cation					10	0d. Insid	e City Limits
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23a or 28	Funeral Director	10e. Street end Number 702 Burgundy	Drive	2			10f. Zip		.0850		10g. Citizen of United			
dano. Tambana and samular mast be notified at	by	11. Maritel Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Divo		12. Was Deced Armed Ford 1 ☑ Yes 2 If Yes, Give Year or Dat	es?				dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Ble Specifi	ce - America ck, White, e		٦,
nygians. oth, the Medical	Completed	(Specify only h Elementary/Secondary (0-		cetion le completed) College (1-4	4or 5+)	16e. Deced (Give life. L			pation during most of work d)	king	16b. Kind of B		lustry	
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em 27 le other tra		Margaret V.	Smith,	/ Daught	er	19013	Jone	esvi	lle Terra	ace, Poo	lesvill	e, MI	20	837
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has been signe ge 2 should be	Completed b	Hypertensi	on		•					24e. Wes	en eutopsy med?	con	ileble pr	sy findings for to of cause
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To the Funeral Director: After th completely filled in by tha funeral		4 Homicide	termined	28e. Place of building	f Injury - At h , etc. (Specii	ome, farm, stre	et, factory,	office		28f. Location (S City or Tow		er or Rurel	Houte I	Vum <i>ber,</i>
pletely fil	edicai	29a. Certifier 1⊠ Cert (Check only one) 1⊠ Cert 2 Med	ifying Phylical Exemi	eiclan: To the be ner: On the basi and menne	is of exemine	wiedge, deeth tion end/or inv	occurred e estigation,	t the tir in my o	ne, dete end plece, pinion, death occur	end due to the d red et the time, d	euse(s) end me date end place,	enner es ste end due to	eted. the ceu	se(s)
To the	N	29b. Signature and title of or	nitier	col	7	1111	29c.	Licens	e number	-	29d. Date signe	d (Month, E	Dey, Yes	ir)
		30. Neme and eddress of pe	SORVER	thu moleted cause	of aboth /Ita	n 23a) (Tune 5		0139	77		January	13,	199	8
Stat		Robert Millm 31. Dete filed (Month, Pay, Y	an, M	.D. 978	7 Medi		iter l	Driv	ve #150, 1	Rockvill	e, Mary	land	208	50



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 10, 1998 **Physician** Kelon Robertson JANUARY 18:15 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RONE If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Hours 1♥M 2□F Yrs NONE Director 21, 1997 MARYLAND Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or itams 23a or 28a-f shot other traumatic event, tra Medical Examiner must be notified as Yes 2□No Director MD. MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 731 RICHMOND AVE. U.S.A. Funeral 20910 72 hours eftar daath 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No by Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry parnit. Pages 1 and 2 should be filed withir Depertment of Haelith end Mantal Hyglane. Important: If itam 27 is marked other than any injury or other traumetic avant Elementery/Secondary (0-12) College (1-4or 5+) NONE 0 NONE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 ANDY PHILLIP ROBERTSON MARTINA 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) MARTINA ROBERTSON/MOTHER SAME AS 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1/14/98 RIVERDALE, MD. 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility 20910 wanterson _M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cadse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examine hysicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): ettanding physicien Box 68760 cartificate be Physician/Medical Due to (or es e consequence of): 88 usa to P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen has 1 ☐ Yes 2 ☑ No 2 No certificeta Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerei 28e. Dete of Injury (Month, Day Year) 27. Mennes of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Naturel 5 Pending death. 1 Yes 2 No Investigation 2 Accident 24 hours aftar deat Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) January 12,1998 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Wolfe Street, CMSC 210, Baltimore, MD2487 N Estelle B. 600 banda 31. Date filed (Month, Day, Year) JAN 15 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Vac Blanche Mitchell Ray January 1998 10, 1:40 PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1⊠M 2□ F Director Yrs 206-24-3431 66 July 28, 1931 Pennsylvania Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-f show event, its Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Derwood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 15922 Indian Hills Terrace Pages 1 and 2 should be filed within 72 hours efter death neart of Health end Manell Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23, any or other traumatic event, it is Menical Exerciting maintry or other traumatic event, it is Menical Exerciting maintry. Funeral 20855 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2X No It Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No þ Specify. 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Dana Edward Mitchell Lois Keller 19e. Intorment's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) James F. Ray/Husband 15922 Indian Hills Terrace, Derwood, Maryland 20855 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 1/12/1998 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Lice 22. Name end Address of Fecility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart tailure. List only one cause on each line. **Physician** tmmediate Ceuse (Finel disease or condition resulting in death) /Medical e Emphysema Years Examiner Due to (or es e consequence ot): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effect death.
24 hours effect of seath.
Funeral Director: After this certificate has been signed by the ettending physician end elevely filled in by the funeral director, page 2 should be deteched for use es the buriel-transit ettending physician end for use es the burief-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence ot): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contributa to the causa of death? 1

Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case reterred to medical examiner? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Manner ot Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours efter dei To the Funeral Director completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 🖾 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. Medical 2 | Medicat Examiner: On the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) D 44157 January 10, 1998

State Registrar 31. Dete tiled (Month, Day, Year)

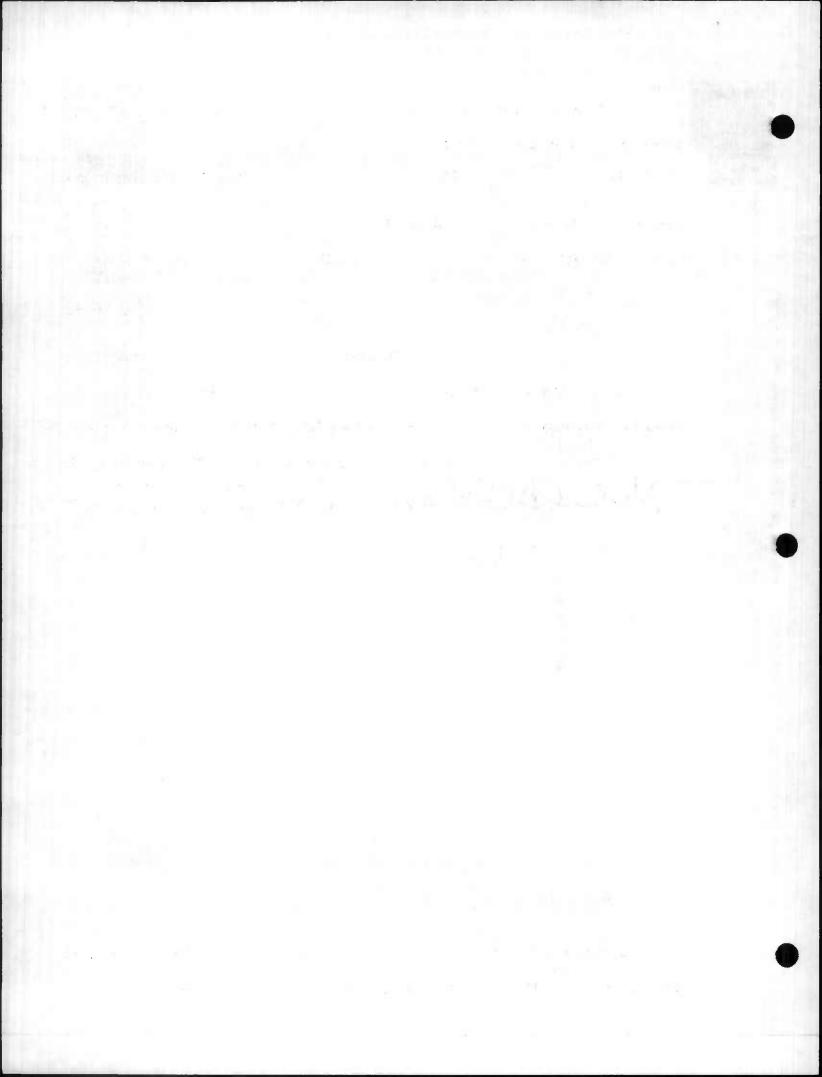
JAN 14

32. Registrar's Signeture

20851

Ira Berger, M.D., 809 Veirs Mill Road, Rockville, Maryland

30. Name end eddress of person was completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Julius Rom Jan 12, 1998 11:40am 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Rockville Nursing Home Rockville Montgomery If Under 1 Year Months Days 5. Sociel Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye July 17, 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. lest birthday) Days 100M 2□ F 78 Yrs. 1919 New 057-12-0500 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 303 Adclare Road 20850 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 XYes 2 No If Yes, Give Yeer or Dates: 1 □ Never Married 2 N Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Accountant State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Rom Anna Fishman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3714 Windom P1. NW Washington DC 20016 and Disposition (Neme of Disposi Joanna Rom-Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 1/14/98 Olney, MD Funeral Service Licensee 22. Neme and Address of Facility Edward Sagel Funeral Direction Daniel Simons 1091 Rockville Pike Rockville, MD 20852 Approximate 23a. Part 1. Enter the cureau, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart fature unit only one cause on each line. Intervel Between Onset end Death Immediete Cause (Finel disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical **Examiner**

permit. Paga Dapartmant o Important: If I

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral', or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours ether and of health and Mantal Hygiene.
Int. if Item 27 is marked other than "natural", or ite into or other traumatic event, "The Mad of Examinary or other traumatic event, "

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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page 2

P.O. Box 68760, physician s tha buria ettending pl been signed to should be det Records, this certificata Division of Vital tha funeral director, After death. in by filled

by Completed Be Certification: To 27. Manner of Death 29a. Certifier

1 Yes 2 No

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Examiner ician end burial-transit The law requires that the death cartificate be executed Physician/Medical Hospital or Attending Physician: 24 hours efter deat Funeral Director: within 24 hou To the Funer complately fil Medicai To the

> State Registrar

31. Date filed (Month, Dey, Year)

29b. Signature and title of cartifier

28a. Date of Injury (Month, Day Year)

29c. License number Old Georgetown Rd. Betherda, Md.

28c. Injury et Work?

1 Tyes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Mia Davidson

5 Pending investigation

6 Could not be determined



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** MARGARFT VIRGINIA RICHARDS JANUARY 14, 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WALDORF HEALTH CARE CENTER WALDORF CHARLES If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) SEPT. 8, 1912 9. Birthplace (State of Country) MARYLAND 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) **Funeral** Sex 1□M 2K F 9. Birthplace (State or Foreign Months Deys 217-68-9596 Director 85 Yrs. Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Heelth end Mental Hydene. Important: If item 27 is merked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be not the an once. 10d. Inside City Limits Director MARYLAND 1 Yes XXNo CHARLES **POMFRET** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 254 BELLWOOD DRIVE by Funeral 20675 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: 11. Marital Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: 3XWidowed 4 □ Divorced Specify: WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be **DENNIS RUFUS ADAMS** LOLA VIRGINIA PICKERAL 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JAMES C. RICHARDS - SON P.O.BOX 71, FAULKNER, MARYLAND 20632 20a. Method of Disposition

1 X Surjai 2 Cremetion 3 Removal from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 4 □ Donation 5 □ Other (Specify) TRINITY MEM. GARDENS, JAN. 16, 1998, WALDORF, MD MARK 6. BROHAWN THE HUNTT FUNERAL HOME, INC. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** ARTERY DISEASE Immediate Cause (Final disease or condition resulting in deeth) /Medical CORDNARY Examiner Examiner or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t EBROVASCULAR DISBASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? page 2 : this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director 25. Wes case referred to medical Be 28. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 27. Menner of Deeth 1 Neturel 28e. Date of Injury (Month, Dey Year) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation n 24 hours efter death.
he Funeral Diractor: A
pletely filled in by the ft death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated. 29a. Certifier To the within 2 To the F 29b. Signature and title 29c. License number 29d. Dete signed (Month, Dev. Year) 1-14-98 MD and eddress of person who completed cause of deeth (Item 23e) (Type, Print) IS TATAWAY RD CLINTON 31. Date filed (Month, Day, 32. Registrer's Signeture

This Stocker Rardell

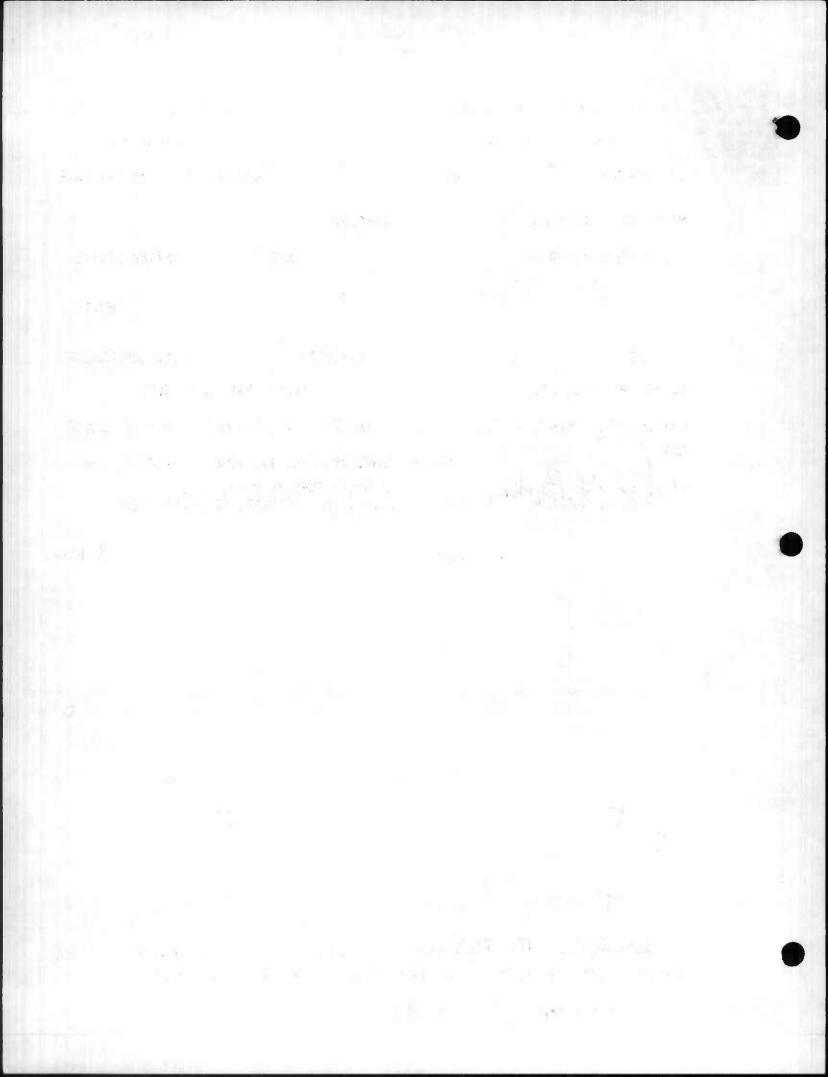
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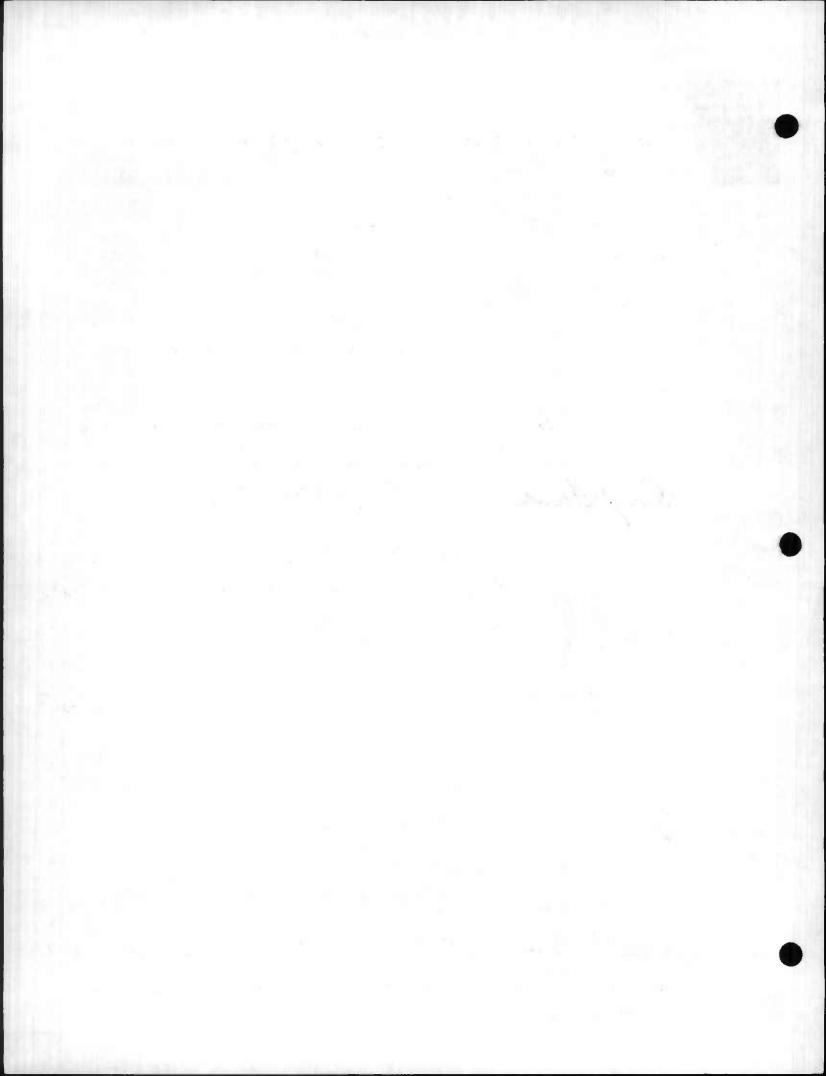
State of Maryland / Department of Health and Mental Hygiene

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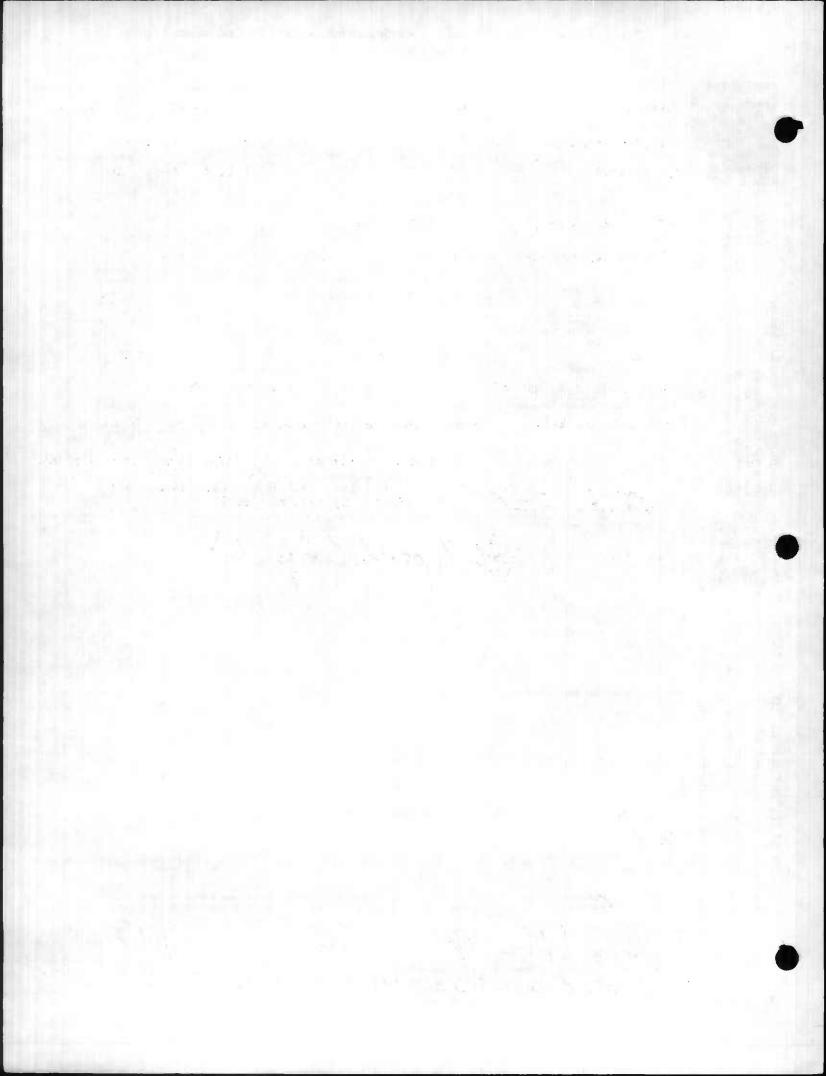
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

bhysician Francher Trans 23a or 28a-1 show and transfer Examinet T	r	4e. Fecility Name (If not institution, given SHADY GROVE 5. Social Security Number 6. 5	s J. Ryan re street end number)					Month	Dey 100	Yeer	
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If Itam 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removel from State	20b. Placa o cemete	of Disposition (Norry, cremetory or	eme of other pla	Jan. 8,	Dete	20c. Location	City or Town,	Stete
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within 24 hours at To the Funaral D completely filled I	29a. Certifier (Check only one) 29b. Signature end title of cartifier 29c. License r 29c. License r						ime, date end plece opinion, deeth occu	e, end due to the urred et the time,	ceuse(s) end me	enner es steted and due to the	cause(s)
mple Med									29d. Dete signe		
	29b. Signature end title of cartifier M, D						51980				
2+1	-	30 Name and address of assess	completed cause of	2 math /lt-m co.	(Tump Bul-1)	V.	11100		January	703,	1118
3)		 Name end eddress of person who Brett Gamma, M. 				D	ve, Rockv	411- 1	1 - 1	20850	



State of Maryland / Department of Health and Mental Hygiene

buoloian	1. Decedent's Name (First, Middle				ificate of		2. Date of Dea	ath	Yeer	3. Time of Deeth
hysician /Medical	Mildred	Ida	Seal				January			9:20AM
xaminer	4a Facility Name (If not institution,	give street and numb	er)			4b. City, Town,	or Location of Deeth	4c. County	of Death	
	Holycross Hospi	tal			5	Silver		Montg	omery	
neral ector	5. Social Security Number 299–16–4819	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. la 91	Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month, De Feb. 6,	1906	9. Birthpla Country Ohi	ce (Stete or Foreigr y) O
rector	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	ation				100	d. Inside City Limits
ğ	MD Montgo	merv		Silver	Spring				- 19	1 ☐ Yes 2 ₺ No
9	10e. Street and Number	IIIC L y		D11.01	10f. Zip Code			10g. Citizen of V	Vhat Countr	y?
Ö	1131 Universit	v Blad We	st #20	09		20902	The same of	USA		
by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ② Widowed 4 □ Divorced	12. Was Decede Armed Force	ent Ever in U,S es? ZINo	S. 13. W		lispanic Origin an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		a - American k, White, et Whi	c.
Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4)	or 5+)		ind of work done O NOT use retire	oation during most of d)	working	16b. Kind of Bu	Home	
ပိ	12 17. Father's Name (First, Middle, I	act)		но	memaker	18 Mother's	Neme (First, Middle,			
o Be	Robert White						oline Woe		-/	
F	19e. Informant's Name/Relationsh			19h Mailine	Arldross (Stroo		r Rurel Route Numbe		State Zin C	Code)
			(000)				SIlver Sp			
	Harry Anderson ' 20a. Method of Disposition	raney	(son)		ition (Neme of etory or other pla		Date	20c. Location -		
	1 ☐ Burial 2 🖺 Cremation		110				1/11/00			
	4 Donation 5 Other (Sp	**	Met	ropoli	tan Crei	natory	1/11/98 Francis J	. Colli	ria, is Fur	virginia neral
	21. Signature of Funeral Service L 23a. Part1. Enter the disease, or	Dil		Hor Sil	ne, Inc. Lver Spr	500 Ting, MI	Iniversity 20901	Blvd.	West	
edical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	e. <u> </u>		es e conseque		Anfa	retion			
-		d								
rsiclan/Med	Part II. Other significant condition	ns contributing to deat	h but not resu	Iting In the und	derlying cause gi	ven in Part i.	23b. Did	tobacco use co	ntribute to 1	the cause of death?
by Physician/N							10	Yes 2 No	3 ☐ Probe	ably 4 Unknow
Completed b								an autopsy med?	evei	e autopsy findings lable prior to pletion of cause eath?
Comp							10	Yes 2 No	10	Yes 2□ No
Bec	25. Wes case referred to medical					26. Plece of	Death (Check only of	one)		
To	examiner? 1 ☐ Yes 2 No	Hospital: 1 Nnp	atient 2 E	ER/Outpatient	3□ DOA Ot	her: 4 Nursi	ng Home 5 ☐ Resid	denca 6 □Oth	er (Specify)	
0.0	27. Manner of Death 1 Netural 5 Pending 2 Accident investig	28a. Date of (Month,	njury Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ryet rk?]Yes 2 ☐ No		now Injury occur	red	
ertific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place UI	Injury - At ho etc. (Specify	me, ferm, stre	et, fectory, offica		28f. Location (City or Tox	Street end Numb vn, Stete)	er or Rural	Route Number,
edical Certification:		Physician: To the be examiner: On the basis and manner	s of exeminati							
Medical Certification	29b. Signerary end title of certifier	Alm	Mo	,	29c. Licen	se number 34032		29d. Date sign	d (Month, D	ley, Year)
100	Mante Land	0	200				KENSIN	1 1		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month JAN. 13, LIBBY WINIK SCHIMMEL 1998 3:55PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HEBREW HOME OF GREATER WASHINGTON MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | Nonths | Deys | Hours | Min. | Month, Dey, Year | MAY 24, 1901 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 20XF 229-70-9875 Yrs. Director UKRAINE Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MONTGOMERY ROCKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 6121 MONTROSE RD. 20852 Funeral USA filed within 72 hours efter death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decadent Ever in U,S. Armed Forces? 14. Race - American Indien, Bieck, White etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 □ Divorced WHITE "naturel". Completed 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) el Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) HOUSE WIFE OWN HOME Baltimore, Maryland permit. Pages 1 end 2 should be file Department of Health end Mentel Hy Important: If Item 27 is marked other any linity or other treumatic event once. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ABRAHAM WINIK CELIA NEMITZ 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 316 NEW MARK ESPLANADE, ROCKVILLE, MD 20850 RUTH LOEVINGER / DAUGHTER 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) 1/16/98 B'NAI ISRAEL CEMETERY OXON HILL, MD 21. Signature of Funeral Sprace Lipensee 22. Name end Address of Fecility INC. MD 20852 EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MD DANIEL SIMONS 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or he in tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel · AORTIC STENOSIS disease or condition resulting in death) Examiner ARTERIOSCLERATIC HEART DISEASE Examiner The law requires that the death certificate be executed buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying: Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Box 68760. ettending physician Physician/Medical Due to (or es e consequenca of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by DYSPLASIA 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? this certificate 1 Yes 2 No Hospital or Attending Physicien: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28e. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 ☐ Pending investigation 1 Neturat s efter deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pteca, end due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifler Medical To the 29b. Signature and fitty of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D05885 = souML 10

6121 MONTROSE RD, ROCKVILLE

State

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

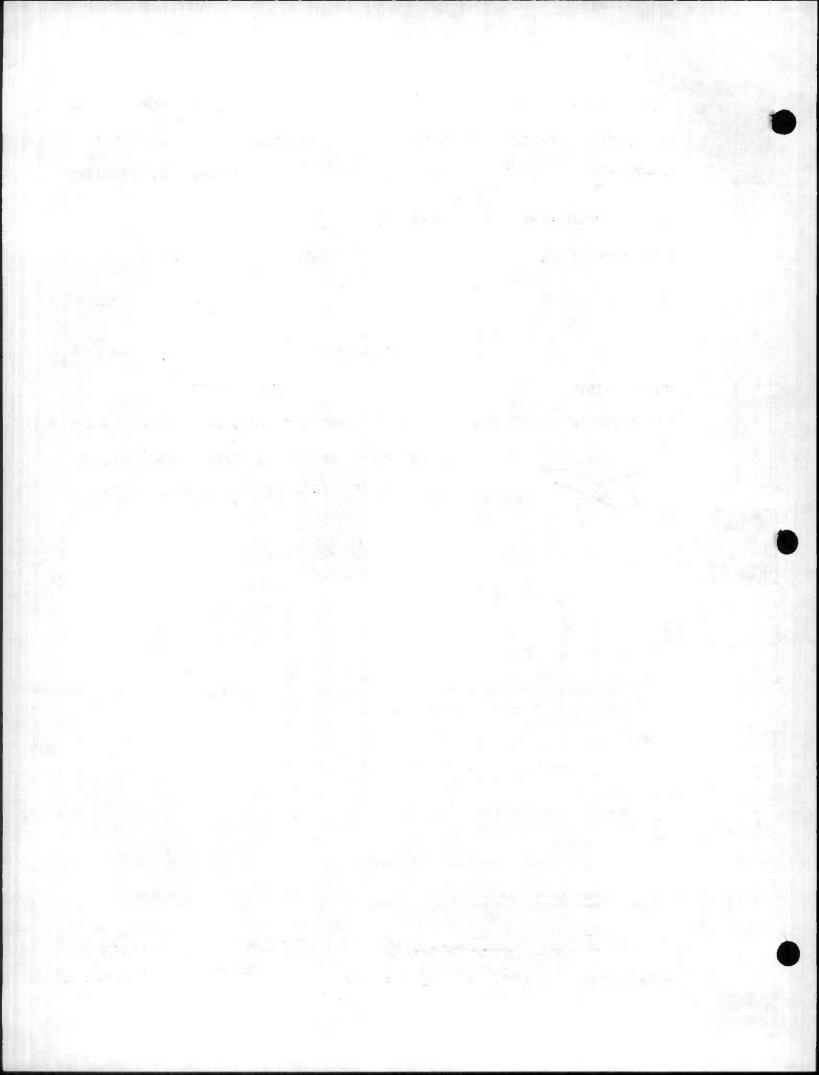
STEVEN 31. Dete filed (Month, Day, Year)

JAN 15

LIDSON

32. Registrer's Signature

Lika Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Marian F. Sharp 10:00AM 14, 1998 January 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 1605 Sherwood Road Montgomery If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 F Months Yrs. Aug. 25, 1923 189-12-9684 74 Colorado Usuat Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1605 Sherwood Road 20902 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Btack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coltege (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mothar's Nama (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Frank Popeck Clara Haines 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel M. Sharp (son) 11612 Tuscany Drive, Laurel, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 1/17/98 Rockville, MD 22. Name and Addrass of Facility Francis J. Collins Funeral 21. Signature of Funeral Sarvice License Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset end Death MVOCARDIAL INFANCT Immediate Ceuse (Final disease or condition resulting in deeth) CONONAND ANGENY DISERSE Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasuiting in death) Last Due to (or es a consequance of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PIBRILLATION (EFT 1 Yes 2 No 3 Probably 4 Unknown BUNDLE BRANCH BLOCK INDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TENSION 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of tnjury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Naturat 5 Pending invastigation

Examiner physician end the buriel-transit

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show ad call Examiner must be notified at

th end Mantal Hygiana.

7 is marked other than "naturitraumatic event, the Wed call.

. Peges 1 and 2 should be fill ment of Health end Mantal Hant: If Item 27 is marked oth jury or other traumatic even

permit. Pege Department of Important: If any Injury or once.

Physician

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Records, P.O.

Division of Vital

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Director: A

To the Hospital or within 24 hours aft To the Funeral DI completaly filled in

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Funeral

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filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medicai þ Completed Be 2 Certification:

28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

SPACARA MID

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

2 Accident 3 Suicide

4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description of the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and titte of cartifie

29c. License number 10 2012 9801 Granaux

29d. Date signed (Month, Dey, Year)

ho completed cause of death (Item 23a) (Type, Print) CHENDERSHOMD

State Registrar

Medicai

31. Date fited (Month, Dey, Year)

JAN 1 6 1998

6 Could not be determined



Lan Daniel MARCHET TO INCHES Condition America Referred THE BOTTOM DEATH AND THE Secretary of the section of the section 100001

						Ce	rtificate	e of l	Death			Reg. No.	1	195	9
منحيط	la.	1. Dacedent's Name (First, Mid	dle, Lest)				7.0	111			2. Dete of De Month	eth	Vee	3. Time o	of Death
hysic /Medi		Ethel D. Sher	er								January	y 10, 1	998	8:15	PM
xami		4a. Facility Neme (If not instituti	on, give street e	and numbe	r)			4	b. City, To	wn, or L	ocation of Deeth	4c. County of Deeth			
	Ш	Brooke Grove N	Nursing	Home					01n	-		Mon	tgome	ry	
neral		5. Social Security Number	6. Sex 1 □ M 2			lest birthday)	If Undar Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, De	y, Year)	9. Birthp	lece (State	or Foreig
ector		217-32-2483	1□ M 2[<u>, </u>	96	Yrs.					Feb. 2	1, 1901		nsylv:	
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at be		3360 Gleneag1	oc Driv	· #)_D			20906				United			
E L	Funeral	11. Maritel Status	12. Was				Was Daced	/as Dacedent of Hispenic Origin? (Spec Yes, specify Cuban, Mexican, Puarto F					ce - Americ		
al', o		1 ☐ Navar Marriad 2 ☐ Ma	rried 1 🗆	1 ☐ Yes 2/12/No					, Puarto	Rican, etc.)	Ble	ck, White,	etc.		
		3 Widowed 4 □ Divorce	IT Y	if Yes, Give 1 ☐ Yes 3(5) Year or Datas:			No Specify:				Specif	y: w	hite		
		15. Decede (Specify only high	nt's Education	latad)		16e. Decedent's Usuel Occupation (Give kind of work done during most o				of word	dea	16b. Kind of B	lusiness/Ind	dustry	
tal Hygiene. d other than "natur event, me Medical	Completed	Eiementary/Secondary (0-12)		laga (1-4or	r 5+)	life. DO NOT use retirad)					ing				
		12	0)		Co-Owner							thing		
0 0 E		17. Father's Neme (First, Middle	i, Last)			18. Mothar's Name (Fin						Maiden Sumer	na)		
-	2	Peter DeRoach									a Shup				
Important: If Item 27 Is marked any injury or other traumatic a once.			9a. Intorment's Nema/Relationship (Type, Print) Ann Johnson /Executrix								ral Route Numbe	-	, Stete, Zip	Coda)	
		20a. Method of Disposition	/ BAECUL	.117	20h Pl	lece of Dispo		Road Sarasota, FL 34242 Date 20c. Location - City or Town, Stete						C4-4-	
0		1 ☐ Buriai 2 Cremention	3 □Ramovai	i from State	e Ca	Linco	metory or oth	her plec			1/13/98				
nju.		4 □ Donetion 5 □ Other (1	1	-	-				1/13/30	Brenty	wood,	MD	
any i		100	11/	Unli	1/4.	· A	I nes-F	Rina	1di F	inei	ral Home	. 11800) New		
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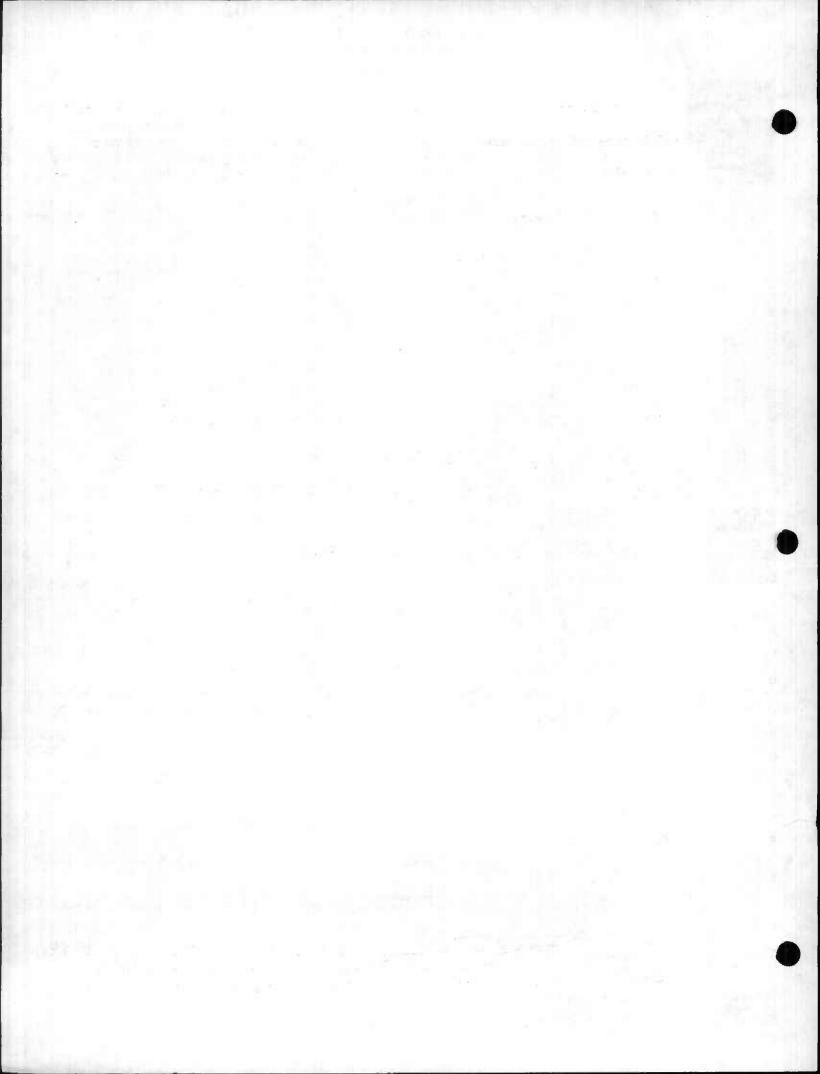
31. Date tiled (Month, Day, Year)

JAN 13 1998

32. Registrer's Signeture Full Savidson-Randelle

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marvin Riggs Shultz, Sr. January 10, 1998 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year 5. Social Security Number 7. Age (In vrs. lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 2□ F Months Days Hours Min. 78 Director 219-01-1738 July 10,1919 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. tnside City Llmits Director 1⊠ Yes 2 No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 722 Grandin Avenue 20850 United States death , Funeral 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter nant of Health end Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Automobile Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Charles F. Shultz treumetic Della W. Gaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2
Department of Health e
Important: if item 27 is
any injury or other tree Edna A. Shultz/ Wife 722 Grandin Avenue, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20a. Method of Disposition 20c. Location - City or Town, State 14, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service License 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, M00089 Rockville, Maryland 20850-2805 23a Parti e, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Couss (F-disease or condition resulting in death) /Medical Gastrointestinal Bleed Examiner 7 Days Due to (or as a consequence of) Examiner Esophageal Varices 2-3 Years The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bnd buriel-tran Due to (or as e consequence of): Box 68760. Laennec's Cirrhosis 10 Years Physician/Medical the Due to (or as a consequence of): use as ettan for u P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Pneumonia of Vital Records, þ 8 Completed 24b. Were eutopsy findings evelleble prior to 24a. Was an autopsy completion of ceuse of deeth? 1 ☐ Yes 2 ₩ No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes cese referred to medicel 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Physical or after death.

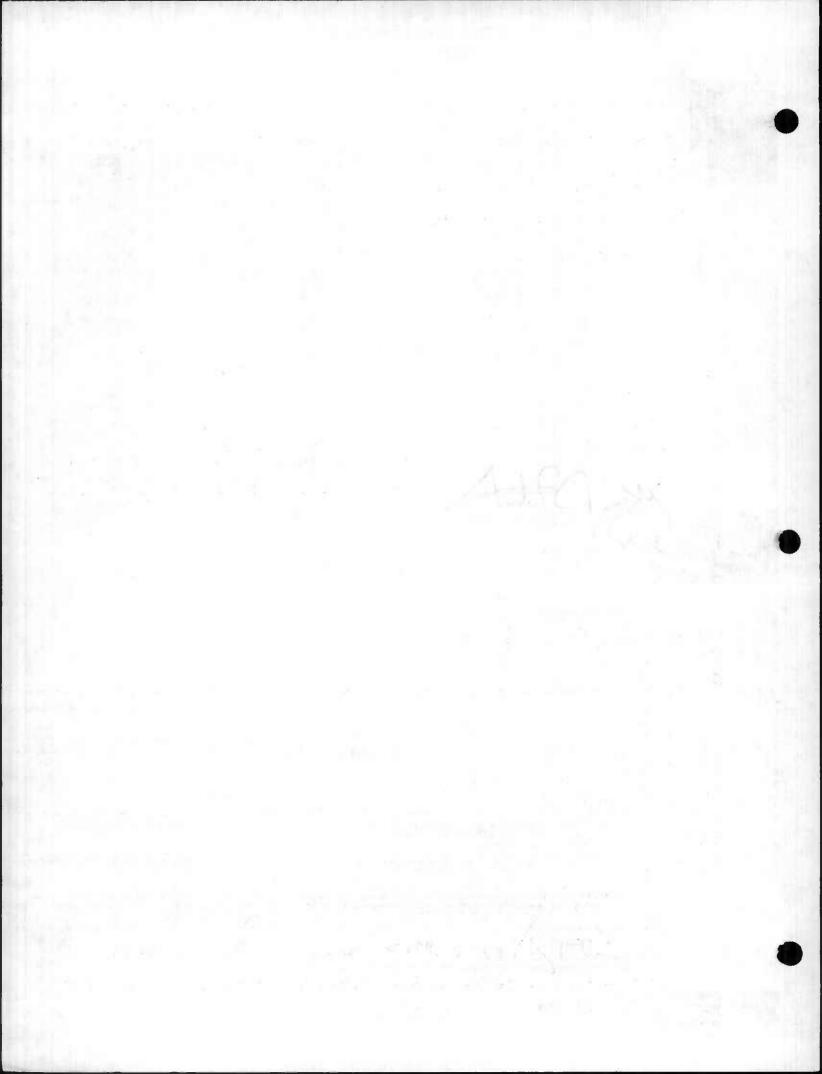
neral Director: After this filled in by the funeral di After this Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 XNaturel 5 Pending Investigation Injury 1 Tyes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral D 29a. Certifie to continuous Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Limited Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medicai To the Hosp within 24 ho To the Fune complately fi 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) D07471 January 13, 1998 Paul T. Noone, M.D. 50 West Edmonston Drive, #207, Rockville, Maryland

32. Begistrar's Signature

hie Davidson

State Registrar

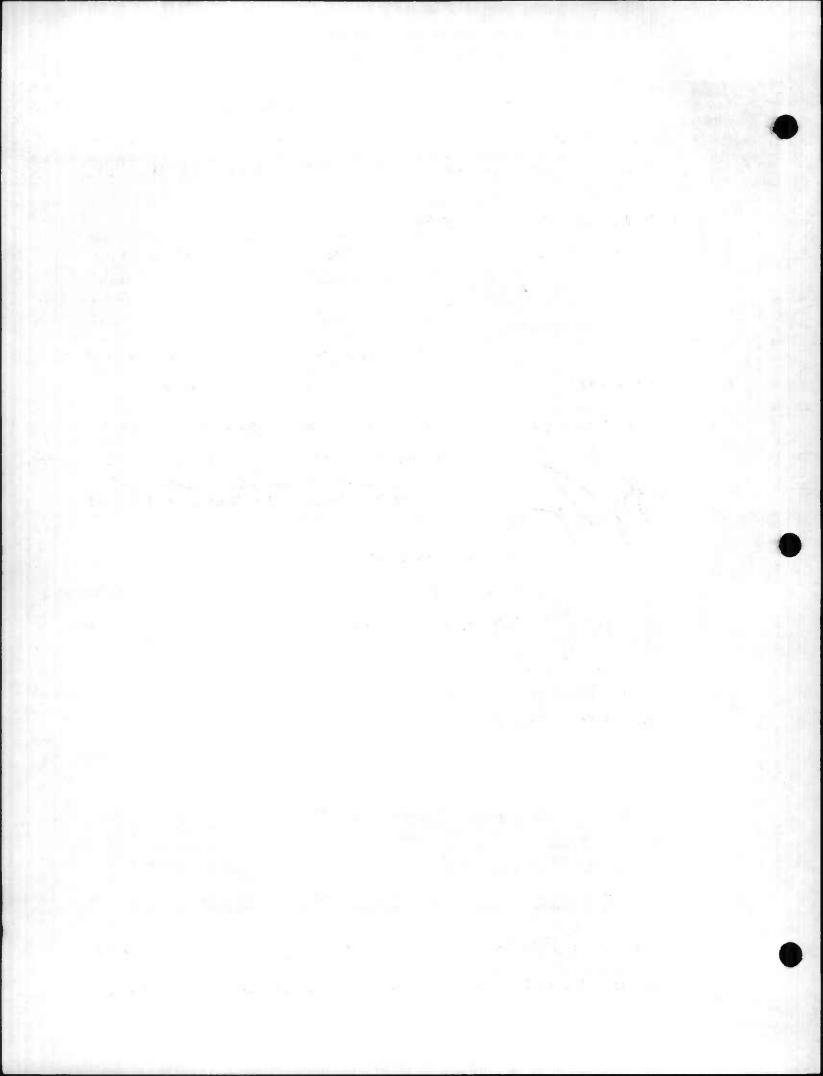


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Silberman January 14, 1998 Mever H. 12:45 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug. 15, 1915 Pew York 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 □ F Deys Hours 152-01-4479 82 Yrs Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner past be notified at 1 ☐ Yes 2 ☐No Maryland Montgomery Director Bethesda 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 5225 Pooks Hill Rd. 20814 238 United States Funeral 72 hours after death 12. Was Decedent Ever In U,S. Armed Forces? ½∏ Yes 2 □ No If Yes, Give Year or Detes: 1943-45 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married ò Maryland 21215-0020 Specify: White 1 Yes 2X No Specify: þ 3 Widowed 4 □ Divorced "naturel". Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) Self Employed Wholesale Souvenir other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fill to the of the health and Mantal H tant: If Item 27 is marked oth jury or other traumatic even Be Leon Silberman Anna (Unknown) 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Norman Silberman (Son) 10209 Arizona Circle, Bethesda, MD Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Removal from State Department o Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 1-16-98 Falls Church, Virginia King David Mem. Gdns. 21. Signature of Juneral Service & Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Aspiration Pneumonia Examiner Hours Due to (or es e consequence of): Systolic Cardiac Arrest Hours The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Coronary Artery Disease Box 68760, physician Years Physician/Medical the Due to (or es e consequença of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown Multi Infarct Dementia Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 200No this certificate Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Aftar 5 Pending investigation 1 Naturel al or Attendir s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours Hospital Medical 102 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier To the I within 2 To the I complet 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Sicoun 25 MD 40576 Ja, 14, 1998 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) R. Oskoui M.D., 3301 New Mexico Ave., Suite 202, Washington, D.C. 20016 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Julia Tavidson-Randoll **JAN 1 5** Registrar

(2:48

Silberman 1-14-98



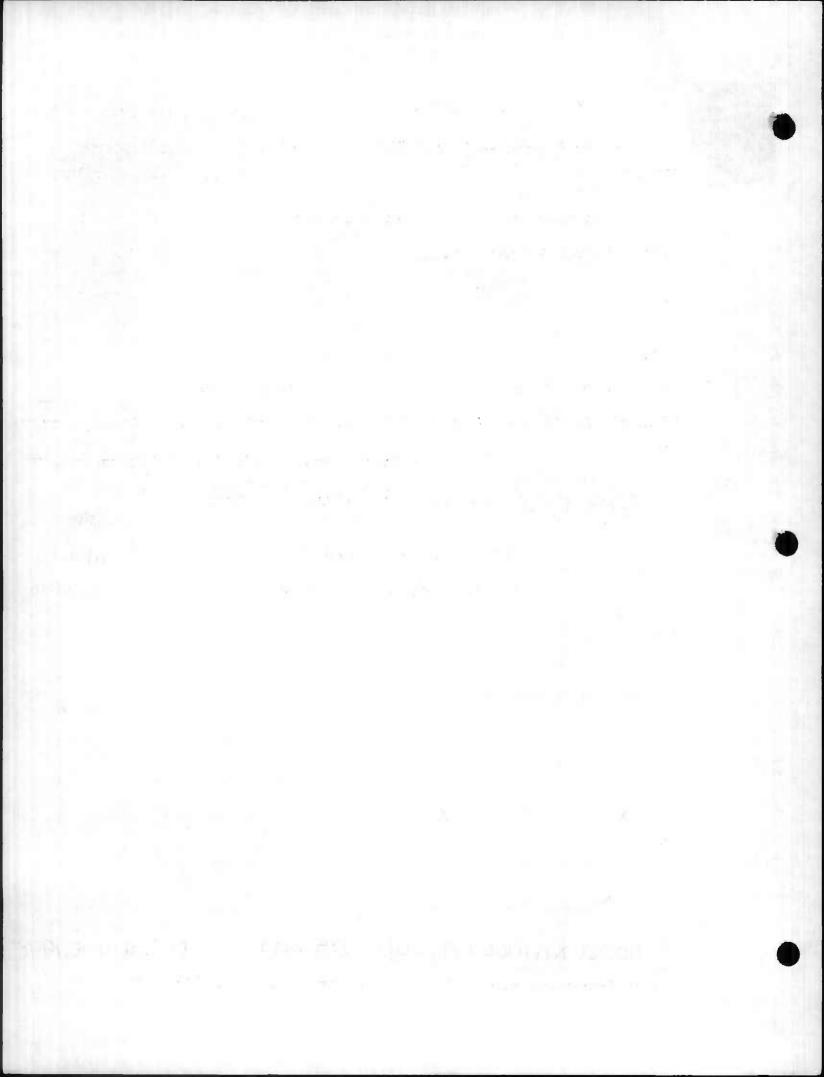
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** VIOLA SIMPSON 1304 P 10 1998 /Medical DOUGCY 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death / 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL

The fine was birthday of the under 1 year MONTGOMERY

9. Birthplace (State or Foreign Country)

933 Maryland ROCKVILLE 8. Date of Birth (Month, Dev. Year)
Aug. 13, 1933 **Funeral** Months Days Hours Min. 1 ■ M 2 X F 64 217-34-0595 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at 1 Yes 2 □ No MD Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7733 Mineral Springs Dr. 20877 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Black à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Housewife Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Raymond H. Gibson Viola Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code 20877 Victoria A. Simpson (Dau.) 7733 Mineral Springs Dr., Gaithersburg, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emory Grove Cem. 1/15/98 Gaithersburg, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, 20850 ROCKVILLE, MD ense, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, to List on y one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examine sician end buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) physician s the buriel Box 68760, Physician/Medical Due to (or as e consequenca of): 88 USe detached for u P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings eveileble prior to Completed 24a. Was an autopsy performed? completion of ceuse of death? 2XNO 1 Yes 2 No Division of Vital 25. Was case referred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending i or Attendin s efter death. i Director: Aft 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide Mospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) Meera Kanhouwa, M.D. 9901 Medical Ctr. Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidson Registrar JAN 13 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death January 10, 1998 Year HERSCHEL SKELTON 12:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18913 Glendower Road Gaithersburg Montgomery Hours Min. 8. Date of Birth (Month, Day 7) 5. Sociel Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Days 521-42-1593 94 Yrs. Arizona Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18913 Glendower Road 20879 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) painter / carpenter own business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Herman Powell Skelton Myla Cerena Helm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Selena Fritz (daughter) 18913 Glendower Road, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-11-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PROSTATE CANCER YEARS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed?

Physician /Medical Examiner

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Box 68760

P.O.

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Division or Attending **Physician**

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Examiner

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filed within 72 hours efter

Baltimore, Maryland 21215-0020

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Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai

1 Yes 2 No

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

CTR DR ROCKVILLE MD 20850

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 PNatural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

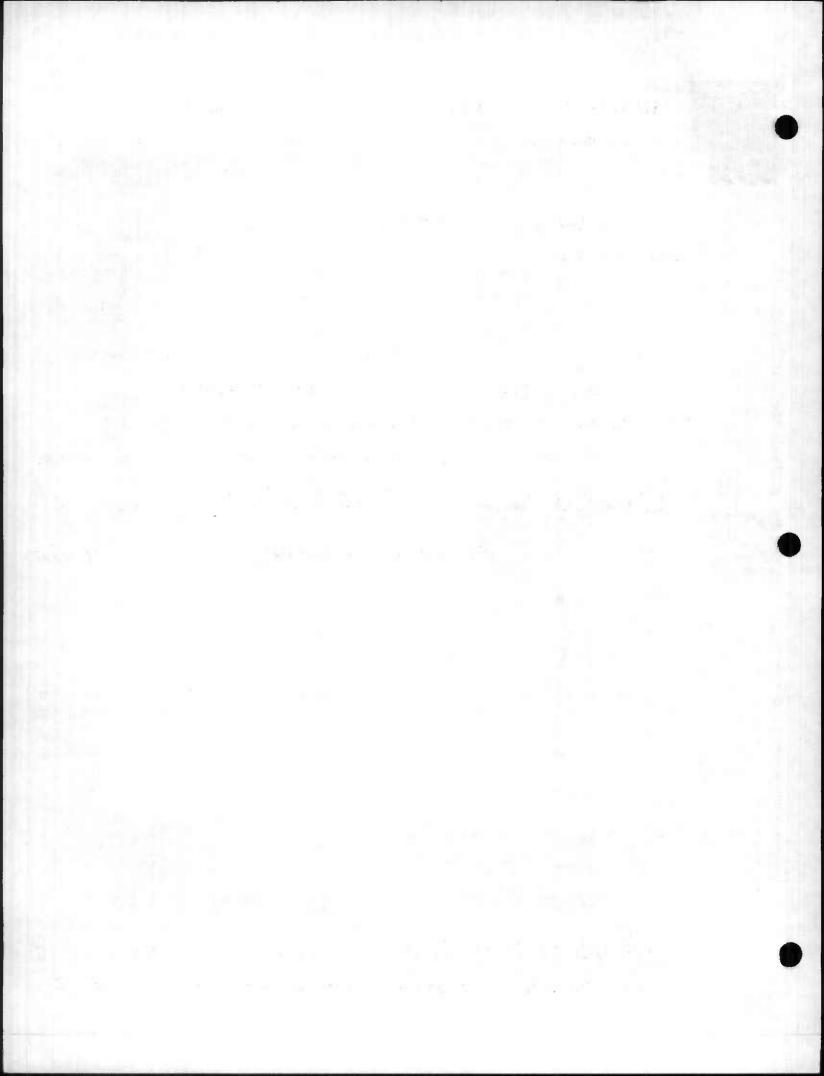
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph HAGGGRTY 9707 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature Alia Davidson

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Bay 6/95



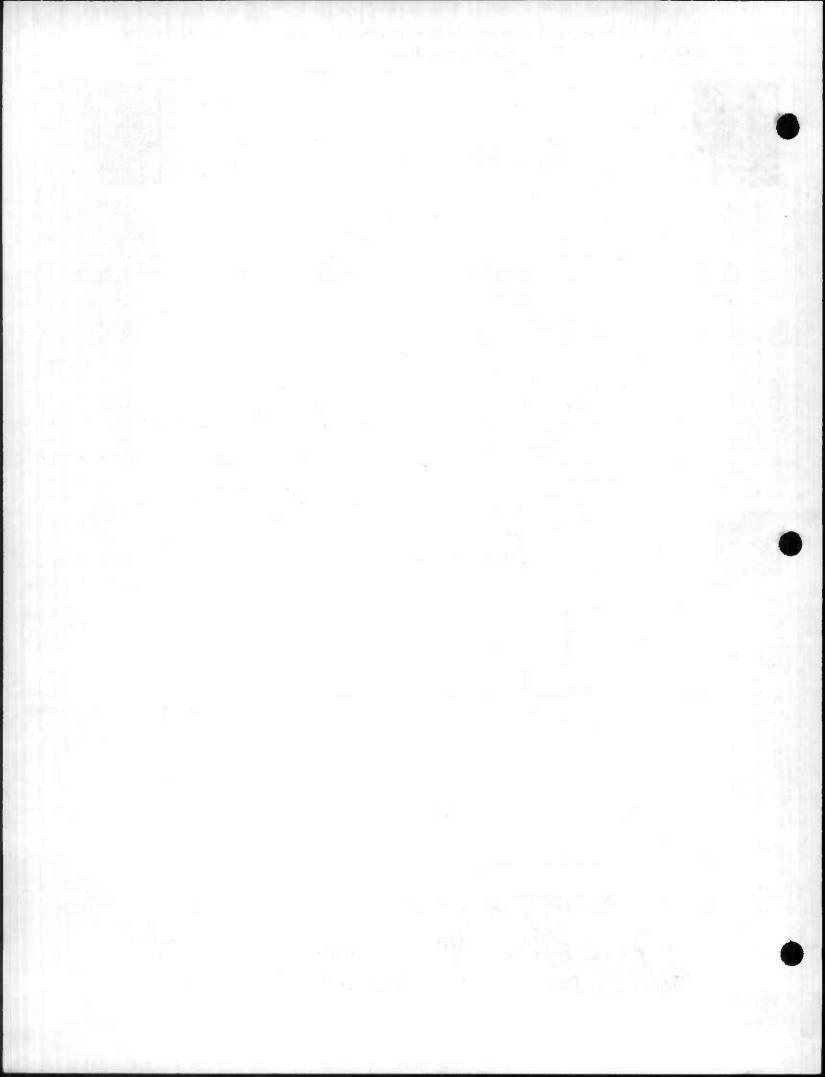
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth **Physician** Month 1998 1:58 AM Leonora L. Stettner January 11, /Medical 4e. Facility Name (If not Institution, give streat end number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Silver Spring Holy Cross Hospital Montgomery 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth (Month, Dex Y 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2 F Days Hours Wisconsin 218-41-0750 83 Yrs. Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 901 Arcola Avenue United States Funeral permit. Peges 1 and 2 should be filed within 72 hours efter deeth Department of Health end Mental Hygiene. Internet of Health and Mental Hygiene. Internet 21 is merked other than "natural", or iteme 23 any injury or other traumatic event, in a Medical Experiment many. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No g 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Economist Co-op 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyril Herrick Emily Devereaux 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 706 Silver Spring, Avenue, Silver Spring, MD 20910 Nina K. Rogers (daughter) 20b. Pieca of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 1-13-98 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 22. Name end Address of Fecility
Rapp Funeral Services, P.A. 21. Signeture of Funeral Servica Licansea 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Entar tha diseese, or complications that causad the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Onsat and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Mumoria Examiner Due to (or as a consequence of): Physiclan/Medical Examiner iclan end buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. physiclan The law requires that the death certificate be the Due to (or as e consequenca of): 98 signed by the et P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? pege 2 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ inpatient 2 ER/Outpatient 3□ DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 Yes 2No this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturet 2 Accident efter death. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) completely filled in by 4 D Homicide hours Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signeture and titla of certifie 29c. Licansa number 29d. Day's signed (Month, Dey, Year) leted cause of deeth (Item 23a) (Type, Print) AVE KENSINGTON 32. Registrer's Signatura Day, Year) State

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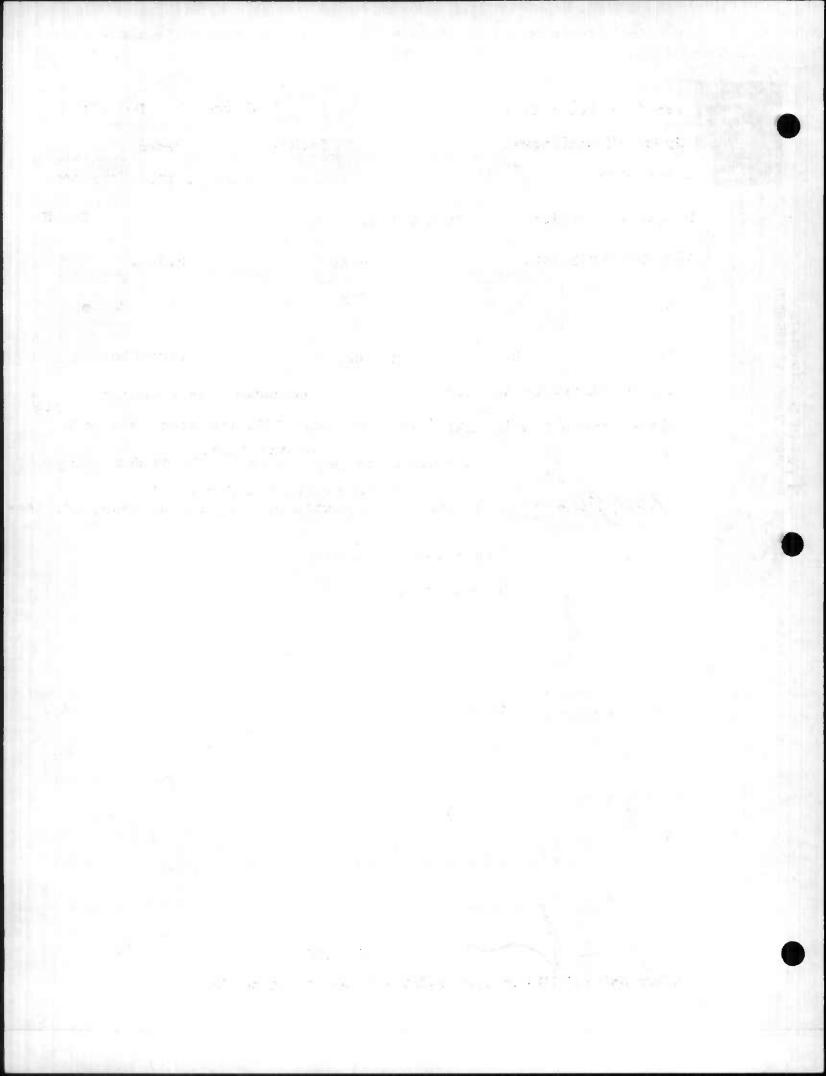
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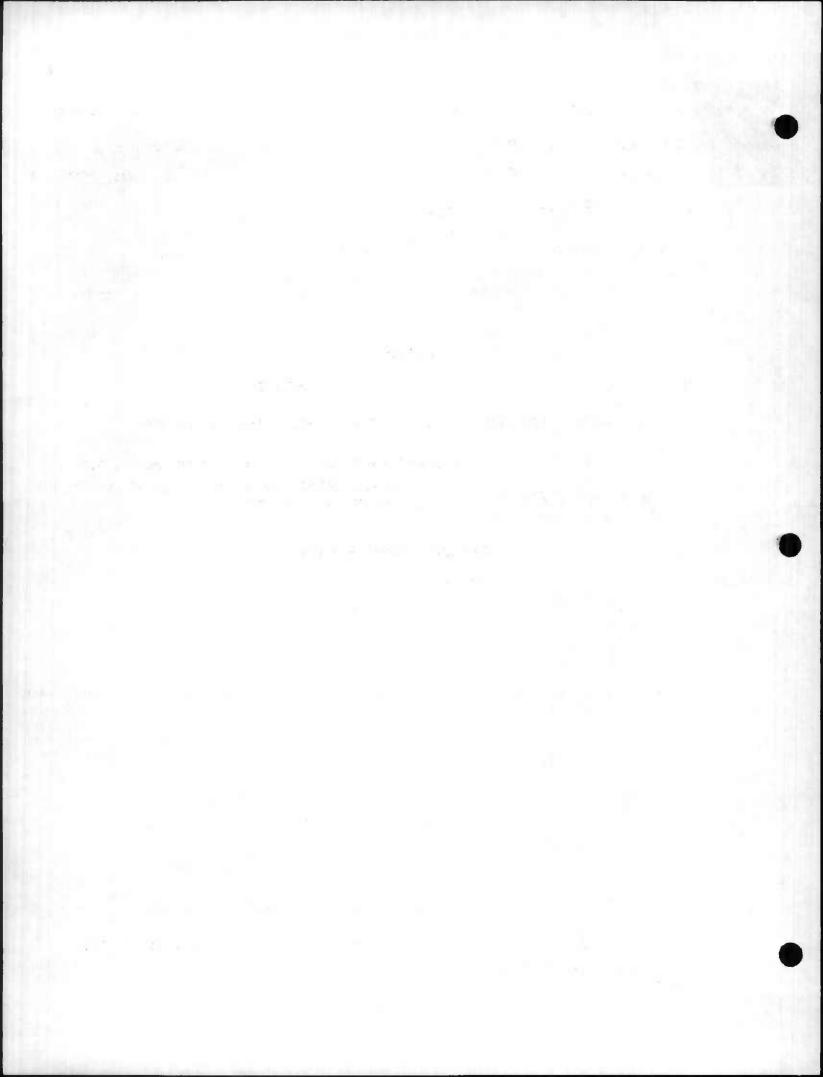


Physicia		Decedant's Name (First, Middle, Last)		Certifi	icate of	Death	2. Data of De	Reg. No.	3. Tima of D
		Willie	C.	tewart			Month	Day Y	'ear
/Medica Examine	-	4a. Facility Name (If not institution, give streat and n		LEWAIL		b. City, Town, or Lo	Cation of Deeth	4c. County of	
Examini	eı	Genesis Elder Care				La Plat		Char	
Funeral		5. Social Sacurity Number 6. Sex	7. Age (In yrs. la		Undar 1 Year	If Under 24 Hrs.	8. Date of Birt). Birthplaca (State or I
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Eran	by F	3 ☐ Widowed 4 ☐ Divorced if Yas, G	2 □ No Bive Datas:	101	Yas 2 No	Specify:		Specify:	Black
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m 27 her tr		Kellie Jamison/soci				olia Dr.			
De off		20a. Mathod of Disposition 1 ☐ Burial 2 🛱 Cramation 3 ☐ Ramoval from		nca of Disposition matary, cramator	n (Nama of ry or othar plac	(a)	Data	20c. Location - Cit	ty or Town, Stata
ortant: Injury		4 ☐ Donation 5 ☐ Othar (Specify)	Met			rematory			dria, VA
Departmen mportant: any injury anse.		21. Signature of Funeral Service Licensee	MQ0817	22. Nar	me end Addra	ss of Facility -Echols	Funers	1 Home	ΡΔ
0500		Hunty Cles	2 TH	P.0	O. Box	567 La	Plata	. MD 20	646
		23a. Part1. Enter the disaasa, or complications thet shock, or haart tailura. List only one causa on	caused the deeth.	Do not antar the	e mode of dyln	g, such as cardiac o	r respiretory er	rast,	Approximete Interval Batwe
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e attending pod for use as	2	• 4	men	~	ner	0			-1
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State of Maryland / Department of Health and Mental Hygiene 98 0 197

					Ce	ertifica	te of	Death			Reg. No.	0	115	111
Dhualais		1. Decedent's Name (First, Middla, I	ast)				14			2. Date of D		Year	3. Ti	ime of Death
Physicia /Medic	_	ELSIE SWAIN		STEWAR	T					JAN	12, 1		2:3	30am
Examin	er	4a. Facility Name (If not institution, g	ive straet and numbe	ur)				4b. City, To	wn, or Lo	cation of Dea	th 4c. Cou	nty of Death	1	
		SHADY GROVE NURS			4144	If I lade	r 1 Year	Rockvi			Mont	gomery		
uneral irector			Sex 7 1□ M 257 9.	Age (In yrs. lasi 5	Yrs.	Months		If Under Hours	Min.	8. Date of Bi (Month, D) Feb. 22	nth ay, Yaar) , 1902	Cou	intry)	TON, D
28a-f show		10a State MONTGOM	ERY	10c. City, TBETHES		Location								ide City Llmits
38 or 28	al Director	10e. Street and Number 5913 IPSWICH ROAI)			10f. Zi	Code 314			10g. Citizen of What Country? U.S.A.				
o'.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 22 If Yes, Give Year or Dates	X ₀	13			dispanto Ori an, Mexicar Specify:		cify Yes or N Rican, etc.)				
natur	eted	15. Decadent's (Specify only highast g	Education	1	6a. Dec	edent's Usu	al Occup	ation	t of workin	20	16b. Kind o	Business/I	ndustry	
the Mer	Completed	Elementary/Secondary (0-12)	College (1-4o		lifa.	iva kind of work done during most of working a. DO NOT use retired) EMAKER OWN HOME								
d oth	To Be (17. Father's Name (First, Middla, Last GEORGE SWAIN					18. Mothe			e, Maiden Surr	ama)			
EE		19a. Informant's Name/Relationship	(Type, Print)		19b. Mai	iling Addres	s (Street	and Number	er or Rura	Routa Numl	per, City or To	vn, Stata, Zi	ip Coda)	
Item 27 I		MARIE S. PENSYL	DAUGHTER	5	913	IPSW	CH 1	ROAD,	BETH	ESDA,	MD 208	14		
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spec		.0		position (Na amatory or o			1	Date /15/98	20c. Locatio			
Important: If any injury or once.		21. Signature of Funeral Service Lice	neod 1101			JOSEPI	nd Addre	SS of Facili	1/15/98 WASHING		WI AT	7ENU	E, N.W.	
		23a. Pag1. Enter the disease, or co	polications that cause	ad the death. I		WASHI					- man at	-	Annu	xlmate
aminer	Examiner	disease or condition resulting in death)	aH	Due to (or as	SION	N							•	
ing physician and e as tha bunal-transit	ai Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c	Due to (or as	s a consequença of):									
	/Medical	that Initiated events resulting in death) Last	d	Due to (or as	a conse	nsequence of):								
e ettand id for us	iclai	Part II. Other algorificent conditions	contributing to death	but not resultin	a in the	underlying	euse ai	en in Part I		23h Did	tobacco use	contribute	to the cu	ause of death'
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ior: Aftar the funar	ation:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident Investigati		jury Day Year)	b. Time Injury	of M	28c. fnju Woi 1 □	yet rk? Yes 2□		8d. Describe how injury occurred		curred		
Ineral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of I	njury - At home etc. <i>(Specify)</i>	, farm, s	street, factor	y, office		2		(Straat and Nu wn, Stata)	m <i>ber or R</i> ur	al Routa	Numbar,
T 5 :	edical	29a. Certifier (Check only one) 1 Certifying P	ige, dea and/or l	ath occurred Investigation	at the tir , in my c	ne, date an plnion, dea	d place, a th occurre	nd due to the d at the time,	ceuse(s) and date and place	manner as e, end due	stated. to the ce	use(s)		
To the compla		29b. Signature and true certifier						e number			29d. Date sig	ned (Month,	Day, Ye	ear)
	-	30. Name and eddress of the on will	completed ceuse of	death (Item 23	e) (Tvne		3579	2			JANUAR	7 12,	1998	3
		SWAROOP RAO M.D.	50 West				Suite	e 504;	Roc	kville	,MD 2	0852		
Stat	е	31. Date filed (Month, Day, Year)		trar's Signature										
Dominton		JULY TO	150 SW	W Wall dy	V-/104	della								



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** IDLA 1998 JAN. /Medical 4c. County of Deeth 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Takoma Park

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. (Month, Dey, Year) Washington Adventist Hospital Montgomery 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) **Funeral** 1 M 2 □ K F Yrs 579-30-7059 70 Director May 24, Virginia Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel; or items 23e or 23a-f show any injury or other traumatic event, its fraction Examina man be notified at 1 ☐ Yes 2 ☑ No Directo MD Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20782 6203 Balfour Drive USA Funeral 12. Was Decadent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ₺ No p Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles H. Cooke 10 Bertha Wright 19a. Informent's Neme/Retetionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (husband) 6203 Balfour Drive, Hyattsville, MD Hugh C. Stith 20732 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 1/09/98 Alexandria, Virginia 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signeture of Funeral Service Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical 4 HKINOWY Examiner 11 Examiner physician end s the buriel-trensit certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Box 68760. Qu Physician/Medical Due to (or es e consequence of): 98 11 esn esn for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. the 23b. Did tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably MUnknown Division of Vital Records, b should be 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed page 2 certificate hes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1□ Yes 2No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? Certification: i or Attanding F efter death. I Director: After After 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funerel D Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. 29e. Certifier Medical completely (Check only one) 29b. Signature 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 4987 BATTERY LN. BETHESDA, NO ZOSIG

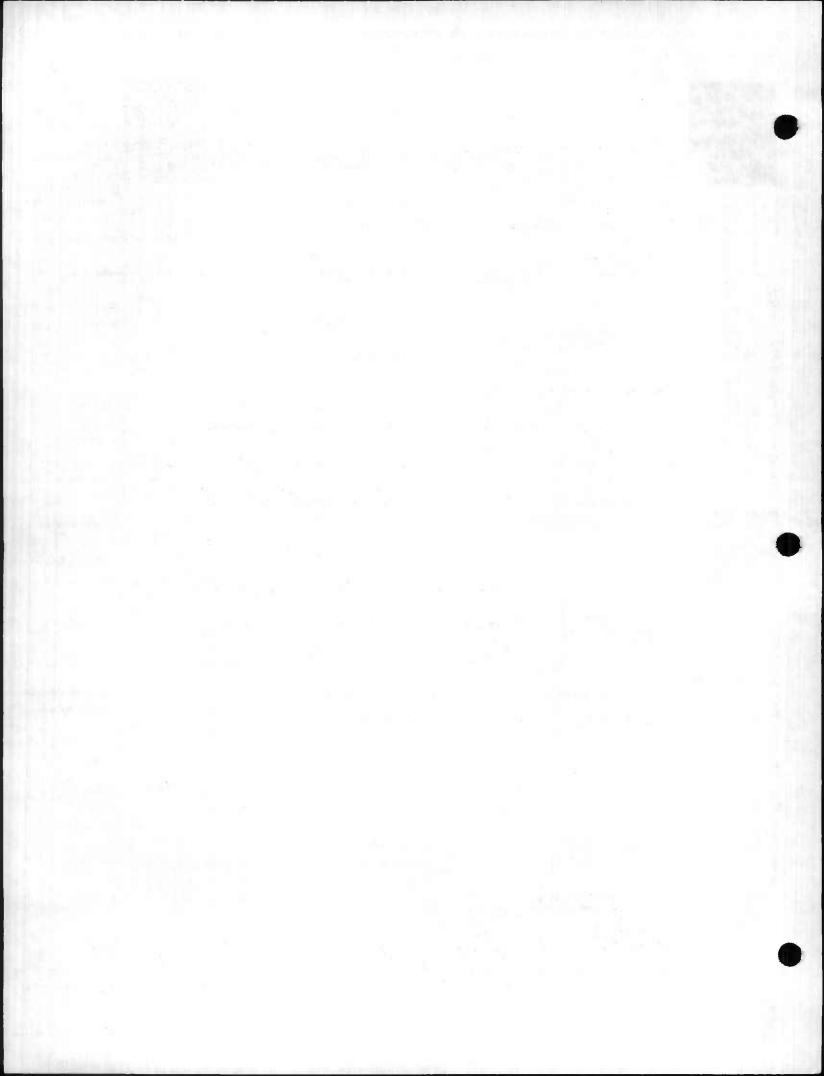
ROBINSON

32. Registrar's Signature

Registrar

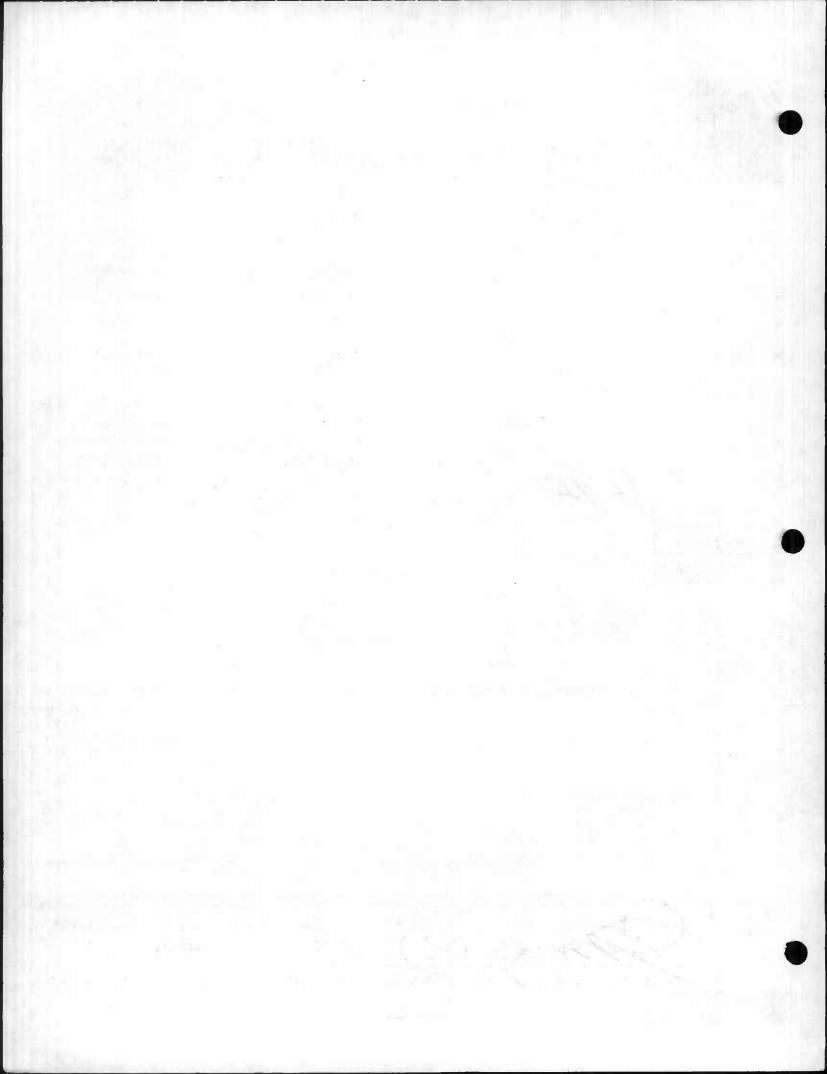
31. Dete filed (Month, Day, Year)

JAN 12 1998



State of Maryland / Department of Health and Mental Hygiene

Dh		1. Decedent's Name (First, Mi	ddle, Last)	- 1 -		rtificate of		2. Dete of De		V	3. Time of De
Physicia /Medica			Lavi	nia Sto	tt			January	7, 199	Year 8	12:30
Examine		4a. Fecility Name (If not Institu	tion, give street end n	um <i>ber)</i>			4b. City, Town, o	r Location of Death		of Death	
		3 Paca Place					Rockvil	le	Mont	gome	ry
uneral irector		5. Social Security Number 165-09-2009 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs	: lest birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, De	th y, Yeer) 4,1918	9. Birthpl Coun Penns	lace (Stete or Fo try) sylvania
No to		10a. State 10b. Cour	nty	10c. C	ity, Town or Lo	cation				11	Od. Inside City L
rishow fied at	to	Maryland Mont	gomery		Rockvil	10					1 ∭ Yes 2[
r 282	Director	10e. Street and Number	801102)		NOCKVII	10f. Zip Code			10g. Citizen of What		try?
23a c	aD	3 Paca Place				208	52		United	Stat	tes
0,1	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	Armed F arried 1 ☐ Yes If Yes G	2 X No		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ No		(Specify Yes or No arto Ricen, etc.)	- 14. Rac Bled Specify	e - America ck, White, e	etc.
fical	Completed	15. Deced	lent's Education hest grede completed	1	16a. Deced	dent's Usual Occu	ipation during most of weed)	and in a	16b. Kind of B	usiness/Ind	lustry
Meg	npie	Elementary/Secondary (0-12		(1-4or 5+)	life. L	DO NOT use retir	e during most or w ed)	rorking			
t t	5	12				Supervi	sor		Board o	f Edu	cation
to b	Be	17. Father's Name (First, Midd						ame (First, Middle,	Maiden Surnem	10)	
marke	ို	Albert Sylves					Jennie				
7 ia n traur		19a. Informant's Name/Relation						Rural Route Number			
om 2	-	Charles H. Sto	ott, Jr./50	1				New Mar	Ket, Mai 20c. Location -	-	
tant: H		1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)	State	cemete <i>ry, cr</i> em lington	National National	al Cemete	0, 1998 ry	Arlingto	on, V	irginia
any ir		21. Signature of Edneral Servi	H	M011	26 Ro	ckville,	Inc., 3	bert A. 300 West ad 20850-	Montgom 2805	y Fun ery A	eral Ho venue,
sician		23a Part Briller he disease, shock, or heart failure. L	or complications that ist only one ceuse on	ceused the dea each line.	th. Do not ente	er the mode of dy	ing, such es cardi	ac or respiratory ar	rest,		Approximate Interval Betwee Onset and Deat
edical miner		Immediate Cause (Finel disease or condition resulting in death)	Cong	estive	Heart H	Failure				7	Months
		resulting in death)	a.	Due to (or as a conseq	uence of):					
sit	Examiner		b. Mass	ive Myo	cardial	Infarc	tion			1 7	Months
and I-tran	xan	Sequentially list conditions, if eny, leeding to immediate									
physician and is the buriel-transit	<u>8</u>	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Hype				ar Disea	se		2	0+ Year
use es the	Physician/Medical	resulting in death) Last	d	Due to (or es e consequ	uence of):					
ottendin for use	clar	2 . 11 . 21									
deteched	Jysi	Part II. Other significant condi	tions contributing to d	eath but not res	sulting In the un	nderlying cause g	iven in Part I.		obacco use cor		
be d	6							10	Yes 2⊠ No	3 □ Prob	ably 4 ☐ Unk
has been s	Completed			-				24e. Was perfo	an autopsy med?	com	re autopsy findii ilable prior to apletion of ceus eeth?
pege .	5							1 U Y	es 2⊠No	10	Yes 2□ No
500	D	25. Was case referred to media examiner?						eath (Check only o	ne)		
his di	0	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatient	3LI DOA		Home 5 ⊠ Resid)
Ine funer	Cetion	1 StNatural 5 ☐ Pend 2 ☐ Accident inves	stigation	of Injury th, Dey Year)	28b. Time of Injury	M 1	iry at ork?] Yes 2 □ No	28d. Describe how injury occurred			
illed in by the		27. Manner of Death 1 St Natural 2 Accident 3 Suicide 4 Homicide 28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Tow			
G 20 5	edical	29a. Certifier 1 Certify 2 Medica	ing Physician: To the it Examiner: On the band man	best of my kno asis of examina ner stated.	owledge, deeth ation and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time, o	cause(s) end ma date and place, a	nner as sta and due to	ited. the ceuse(s)
e le Fi		29ti Signature and Discertif	ier		1	29c. Licen	se number	1	29d. Dete signed	(Month, D	ley, Year)
	-										
To the Fu complete	1	10	200	- 11	1)	D0	7035	J	anuary	8, 19	98
To the Fu complete	1	30, Name and address of perso	n who gampleyed day	e of death (Iter	n 23e) (Prope P		7035	J	anuary	8, 19	98



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 9, Surgenor 1998 3:30PM January /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 14635 Bauer Drive, Apt. 218 Montgomery | KOCKVIII
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 31, 1 Rockville 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 185-07-4823 78 1919 Pennsylvania Usuel Residence of Decedent 10a. State 10h County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2½ No Maryland Montgomery Rockville 2 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? ms 23e or 14635 Bauer Drive, Apt. 218 20853 United States Funeral Herris 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No World If Yes, Give Year or Dates: War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Merried 21215-0020 ð 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Truck Driver Steel Co. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be th and Men 7 is marked treumatic Joseph Surgenor 2 Margaret Dunbar 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra Diane Ramick/ Daughter 811 Duke Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 12, 1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Salve 22. Name and Address of Facilit Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Inc. 100689 Rockville, Maryland 20850-2805 ease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, re. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physiclan Immedia o or se (F disease or condition resulting in deeth) /Medical . Cardiopulmonary Arrest Minutes **Examiner** Due to (or es e consequence of): Examiner Hypertension Years The law requires that the death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting In death) Lest and **buriel-trar** Due to (or es e consequence of): ettending physician for use as the burie Box 68760 Cerebrovascular Disease Years Physician/Medical Due to (or es e consequenca of): P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Division of Vital Records. by Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? certificate has 1 ☐ Yes 2 No or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residenca 6 ☐ Other (Specify) P 1⊠ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation Injury 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide à 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c 29a. Certifier 1反 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.
2☐ Medicat Examtner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. Medical 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 10+1 D44157 January 12, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ira Berger, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851 32. Registrer's Signeture State

ia Davidson

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day KATHERINE MARIE SIMMONS TAYLOR JANUARY 12,1998 11:06 PM 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES LAPLATA PHYSICIANS MEMORIAL HOSPITAL H Under 24 Hrs. 8. Deta of Birth Hours Min. MARCH 28, 1919 If Undar 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthpleca (Stete or Foreign Country) Deys 220-16-5144 78 Yrs. MARYLAND Usual Residenca of Decadant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND CHARLES INDIAN HEAD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 111 WOODLAND ROAD 20640 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 14. Race - Amarican Indian, Bleck, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorcad 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CUSTODIAL WORKER PRIVATE UNKNOWN 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) KELLY SIMMONS ANNIE MONTGOMERY SIMMONS 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DELORES TAYLOR / DAUGHTER 111 WOODLAND ROAD, INDIAN HEAD, MD 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State PLEASAN GROVE CHRUCH CEM. ™ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 1/17 MARBURY, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Libersee 22. Nama and Address of Fecility THORNTON FUNERAL HOME, P.A. ZYDIA C. THORNTON-JOYNSON 3439 LIVINGSTON ROAD INDIAN HEAD, MD 23e. Pert1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiec or raspiratory arrast, shock, or heart failure. List only ona ceusa on each line. Approximata Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) SEPSI Due to (or as a consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Wara autopsy findings availabla prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one)

Physician /Medical Examiner

> and physiclan s the bunal

attending p

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signed by t

page 2

After

To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun-

Physician:

Division

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Physician/Medicai

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Completed

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Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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itsm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "nu

permit. Pages 1 end 2 st Depertment of Health and Important: if itsm 27 is m any injury or other traum

the Maryland

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury thet initiated events resulting In death) Last

6 Could not be

JAN 1 5 1998

25. Wes case referred to medical axaminer?

1 Yes 2 No

27. Manner of Deeth

1 Veturel

2 Accident 3 Suicide

4 Homicide

5 Pending investigation

Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury et Work?

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

AN.

29a. Certifier

frequency of the best of my knowledge, deeth occurred at tha time, dete end pleca, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end mannar stated.

29b. Signature and title of certifier

29c. Licansa number D-44436 29d. Date signad (Month, Day, Yaar)

COVERNO 30. Name and eddress of person who completed cause of death (Item 23e) (Typ), Print)

Ashvin J. Patel, MD 6B Industrial Park Drive Waldorf, Maryland 20602 31. Dete filed (Month, Day, Year)

State Registrar 32. Begistrer's Signeture

AHEDING

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** MILTON T. TAYLOR 12, JAN. 1998 8:40 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY ff Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 120M 2□ F Yrs. 705-18-7997 80 July 23, 1917 RI Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23a or the Medical Examiner must be 1001 Orchard Way 20904 USA Funeral filed within 72 hours aftar death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried & Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etementery/Secondary (0-12) College (1-4or 5+) Hygiena. 12 N/A instrument Government 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mantal Hy, Important: If item 27 is marked othe any Injury or other traumatic event, pages. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Thomas O. Taylor Carrie Atwood 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 20904 Audrey Taylor 1001 Orchard Way Silver Spring MD 20b. Plece of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cremation 3 Removel from State 1/16/98 Brentwood Maryland Fort Lincoln Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Hines-Rinaldi Funeral Home 21. Signeture of Funeral Servica Licansee 11800 New Hampshire Ave. Silver Spring MD 20904 action Approximate Intervel Between Onset and Death 23a. Part1. Enter the displace, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease many years **Examiner** Due to (or es a consequenca of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequenca of) Division of Vital Records, P.O. Box 68760. Physician/Medical that initiated events resulting in death) Lest Due to (or es e consequence of) attending pl signed by the a 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown PV 24b. Were autopsy findings aveilable prior to completion of cause of deeth? should should 24e. Wes en eutopsy Completed is certificate has diractor, page 2 1□ Yes 2 No 1 Yes ZONO or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitet: 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2€ No this funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? Certification: 5 Pending Investigation 1 Naturel 2 Accident 1 Yes 2 No death. octor: A N/A N/A N/A Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify) Direc 4 Homicide • Funeral Dire letaly filled in b N/A N/A 1 Cartifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only one) within 2.
To the F
complet 29b. Signature and title of cartifies 29c. License number 29d. Date signed (Month, Dey, Yeer) 12 D41715 Jan. 14, 1998 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Greenbelt MAryland 20770 7343-A Hanover Parkway

DHMH 16 Rev 6/95

State

Registrar

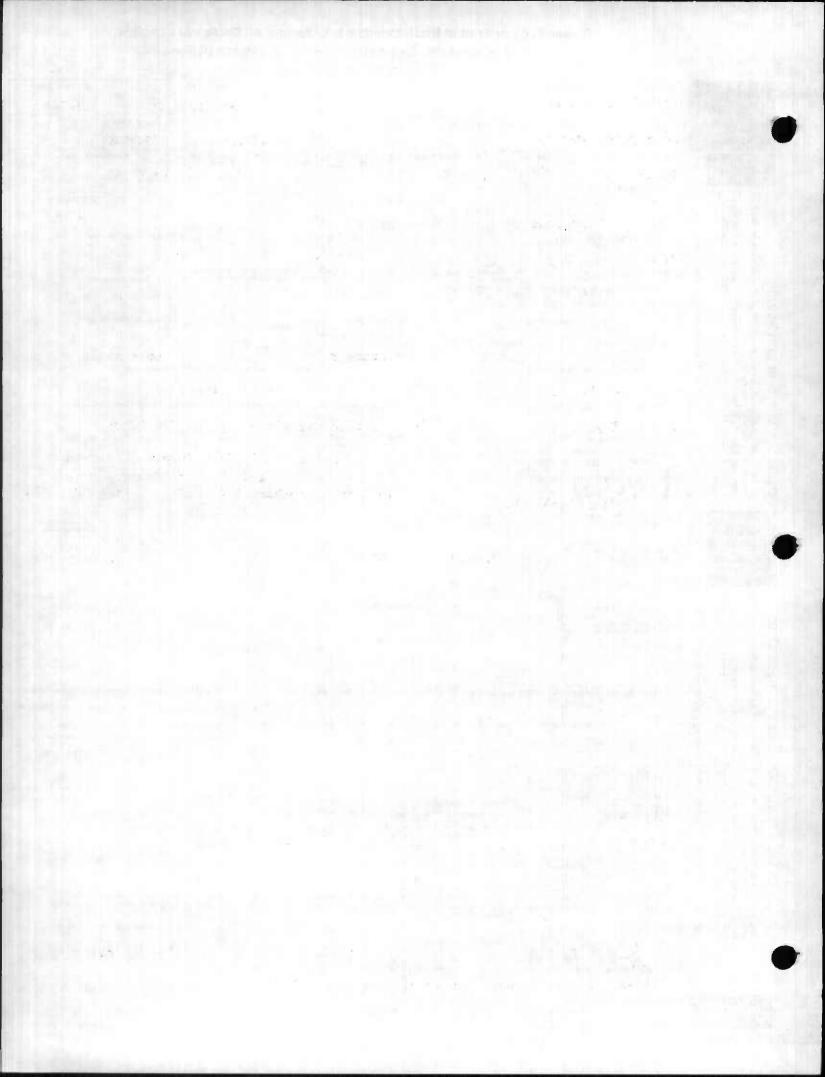
31. Dete fited (Month, Day, Year)

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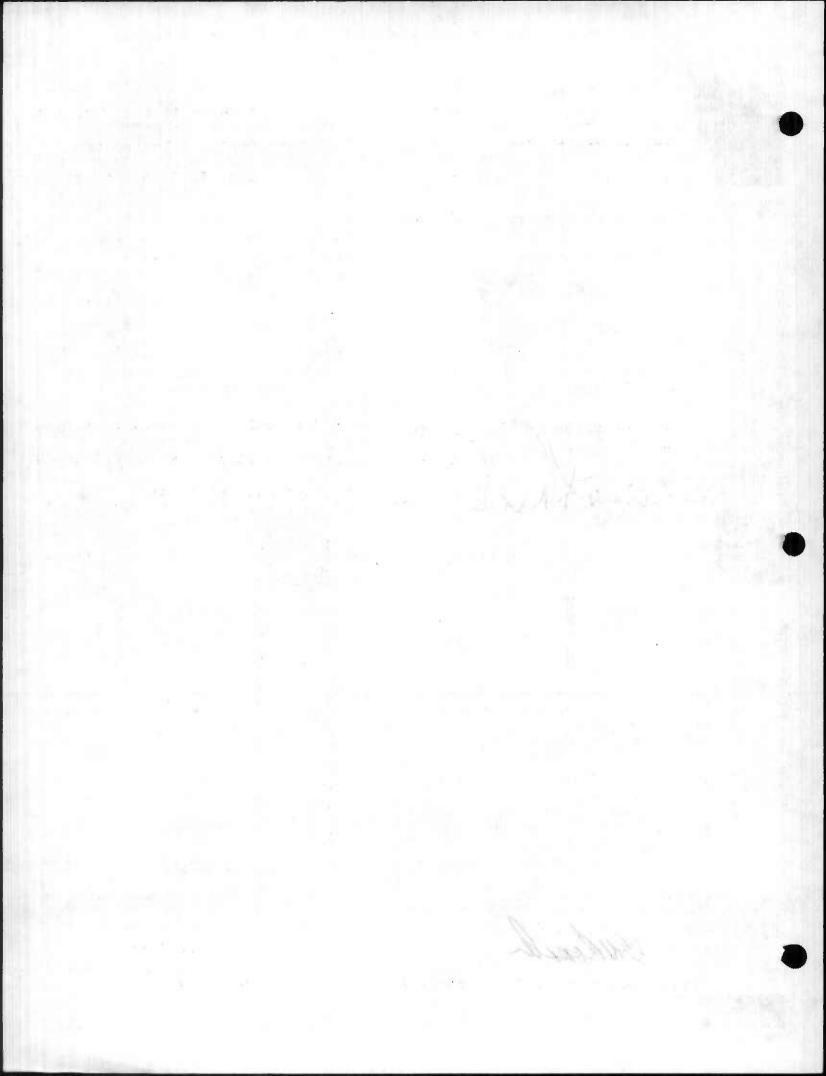
32. Registrar's Signeture

who Davidson-Randell



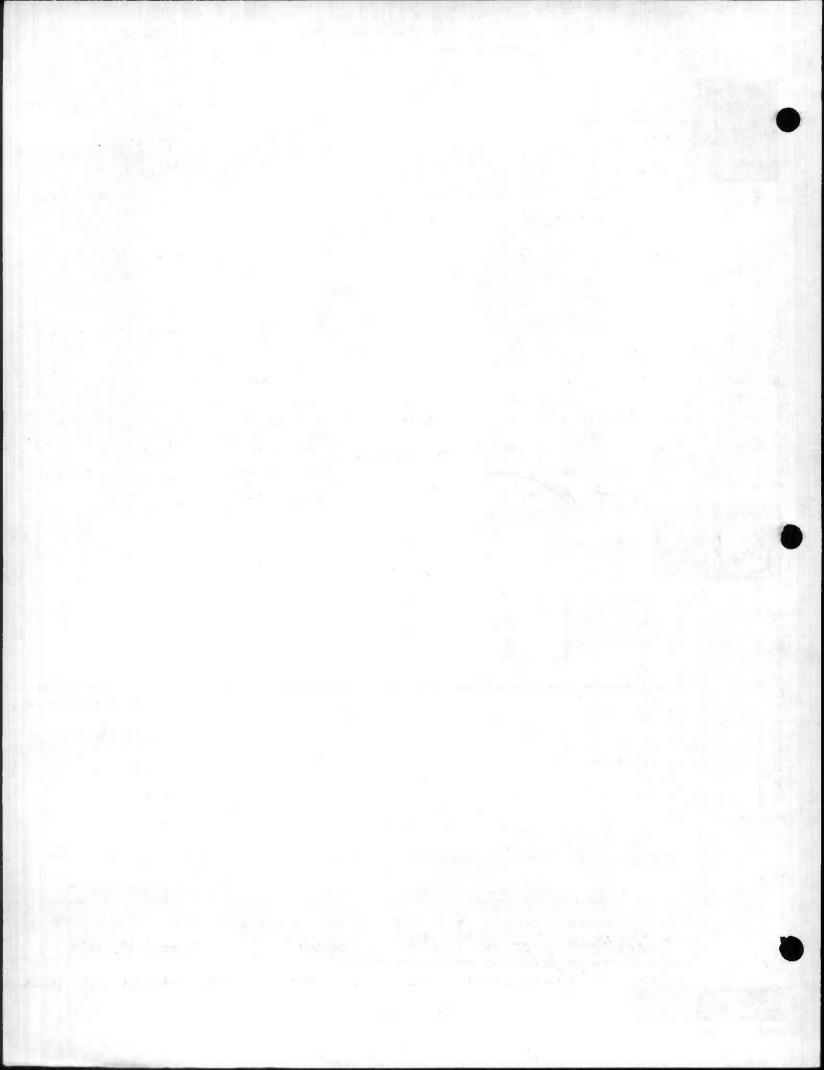
State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		Mariner Health 5. Sociel Security Number 6. S 072 28 5099		Age (In yrs.	. last birthday Yrs.	/) If Un Mont	nder 1 Year hs Deys	Silver If Under 24 Hr Hours Mir	n. (Month, D	Mor ov, Year) 13,1919	9. Birthple Country	ce (State or Foreign
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rat		Jeff Tobin/Son										MD20882
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has been sig	Completed								24a. Was	an autopsy ormed?	eveila	e eutopsy findings abla prior to pletion of cause eth?
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State		31. Date filed (Month, Dev. Year) JAN 14 1000	320 Regist	rar's Signe	ture Randa	.00_						



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har	-	E. Carmel Wils	son, Jr) 314	Winter osition (Neme	· Qı	uarters	Dr., Po					851
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A L		4 ☐ Homicide determined	28e. Piace build	of Injury - At ho ing, etc. (Specify	ome, farm, sti /)	eet, factory, o	ffice		28f. Location City or	Town, Sta		ber or Hura	Route Nurr	nber,
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completely filled in by	8	(Check only 2 Medical Exa	miner: On the b	asis of examinat	tion and/or In	vestigation, in	my o	pinion, death o	occurred et the tin	ne, date a	nd piaca,	and due to	the cause(s	s)
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Registrar

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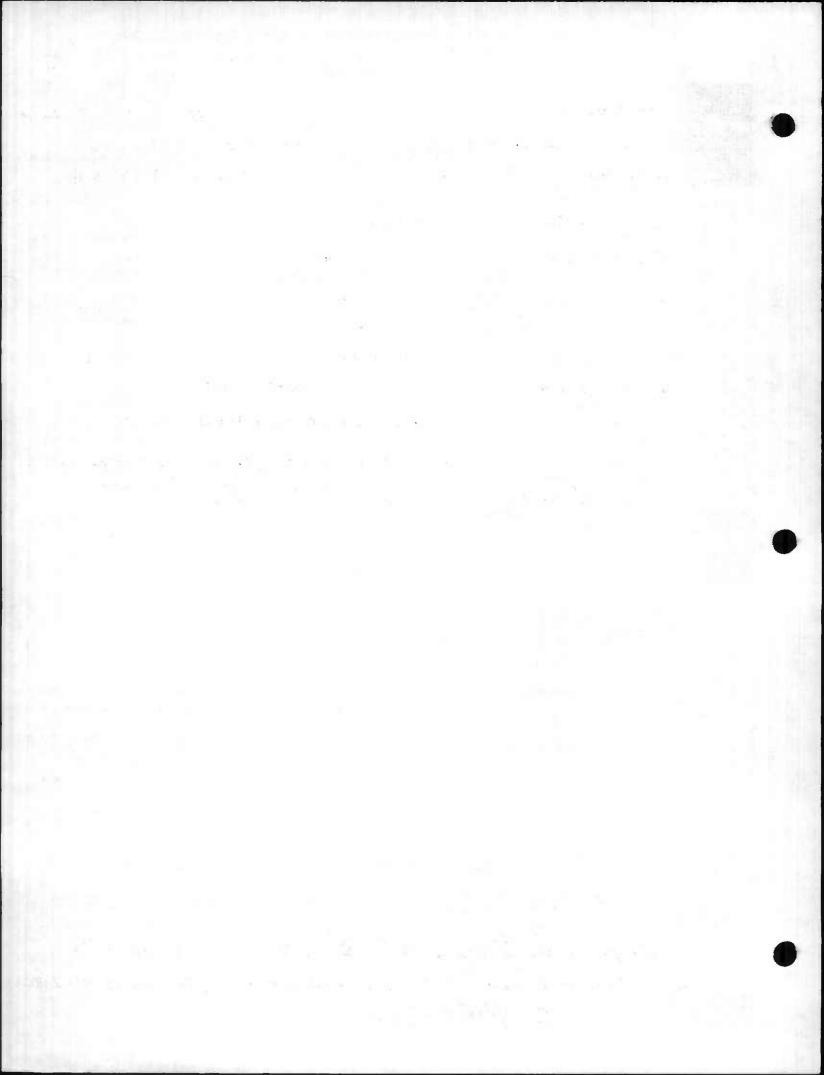
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

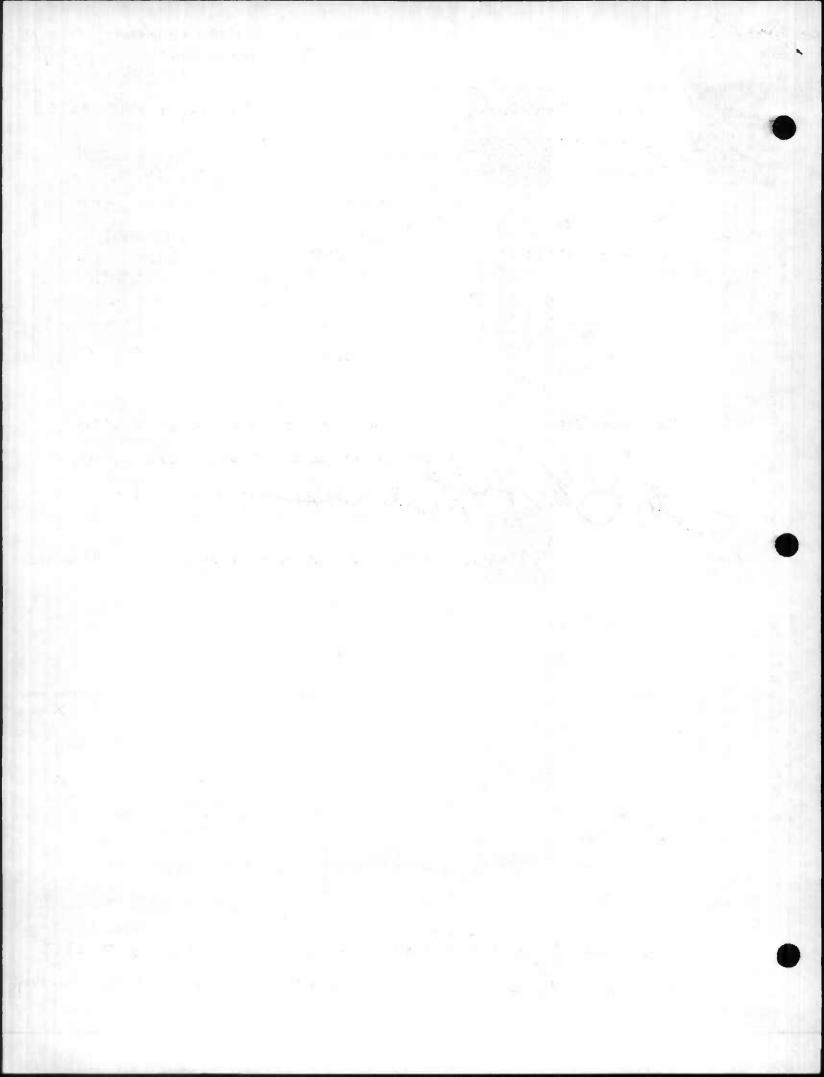
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Division of Vital To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifics completely filled in by the funeral director;		29e. Certifier (Check only	1 Certifying Ph	ysician: To the	best of my kn	owledge,	deeth occurred	et the ti	me, dete end ple	ca, end due to the	cause(s) end r	nanner as st	eted.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Van D. Trinh 18:15 4b. City, Town, or Location of Death 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | March 26, 1959 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 25 F 231-19-6098 38 Yrs. Director Vietnam Usual Residence of Decedent the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at other. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Montgomery 01ney 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 2111 Petersfield Place 20832 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify: Asian ð 3 ☐ Widowed 4 ☒ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) private/beauty Manicurist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Dien Trinh Lien Tang 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Tran Nguyen/friend 19 Ashmond Court, Silver Spring, MD 20b. Place of Disposition (Neme of cemetery, cremetory or, other piece) 20c. Location - City or Town, State 157 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 1/10/98 Silver Spring, MD 21. Signature of Furieral Service Lightness 22. Name and Address of Facility Hines-Ripaldi Funeral Home, 11800 New Dempshire Ave Silver Spring, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Setween Onset and Death Physician /Medical Immediate Cause (Final subarachnoid hemorrhage 48 hours disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): pue physician a sithe burial-Box 68760 Physician/Medical Due to (or as a consequence of): # been signed by the ananding should be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed After this certificate hes 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes 2 No funeral (To the Hospital or Attending Pr within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Exeminer: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier Neurology 29c. License number 29d. Date signed (Month, Dey, Year) Post-doctoral fellow D51795 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Jose Snarez. The Johns Hopkins Hospital. 600 North Wolfe street. Baltimore, Harry 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State This Davidson **JAN 13** Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day COREATHA LYNNETTE TRUESDALE January 1 1998 1535 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's If Undar 1 Yaar | If Undar 24 Hrs. | Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 1 ☐ M 25 F 578-90-0081 Yrs 34 Mar. 8, 1963 | Charlotte, NC Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A Washington Yas 2□No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5502 Eads Street, N. E. 20019 United States 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. Navar Mamad 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 No Specify: **Black** Specify: 3 Widowed 4 Divorced 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Trans. Driver DC Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Melvin Bruce Sarah Ann Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Sarah Ann Bruce -5502 Eads Street, N.E., Wash., DC 20019 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from Stata 1/7/98 Maryland National Laurel, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensea 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. Huton 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onset and Death Immadiate Cause (Final Humma disaasa or condition rasulting in daath) one welk Dua to (or as a consequanca of): Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Causa (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consaguanca of): Dua to (or as a consaguance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical

Physician /Medical Examiner

Physician

/Medical

DC

Director

Funeral

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The law requires that the death certificate be executed

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Box

P.O.

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Division

Attending Physician:

0 Hospital 24 hours

26. Placa of Daath (Check only ona) axaminar' 1□ Yes No Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Natural

5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Streat and Numbar or Rural Routa Number, City or Town, State) 4 Homicide

15 Certifying Phyaicfan: To tha best of my knowledge, daath occurred at tha time, data and placa, and dua to tha cause(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and placa, and dua to the cause(s) and mannar stated. 29a. Cartifiar

29b. Signature and little of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

D27521

30. Name and adds ess of person who complated causa of death (Ifam 23a) (Type, Print)

9500 ANNAPOLLS PL LEACH M.D. 31. Data filad (Month, Day, Year)

State Registrar

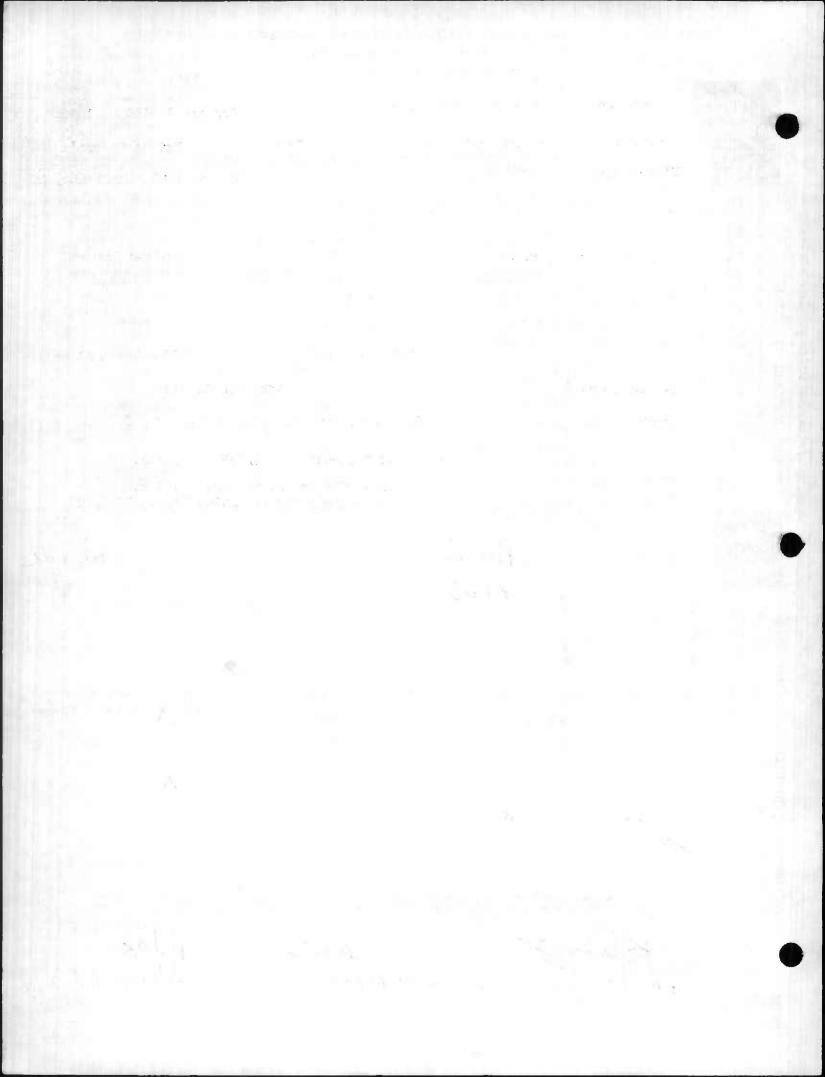
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32. Registrar's Signatura hie Davidson-Randell

DHMH 16 Rev 6/95

#29a. Ho Signed "97 + certif. had to be heri met per F. A.



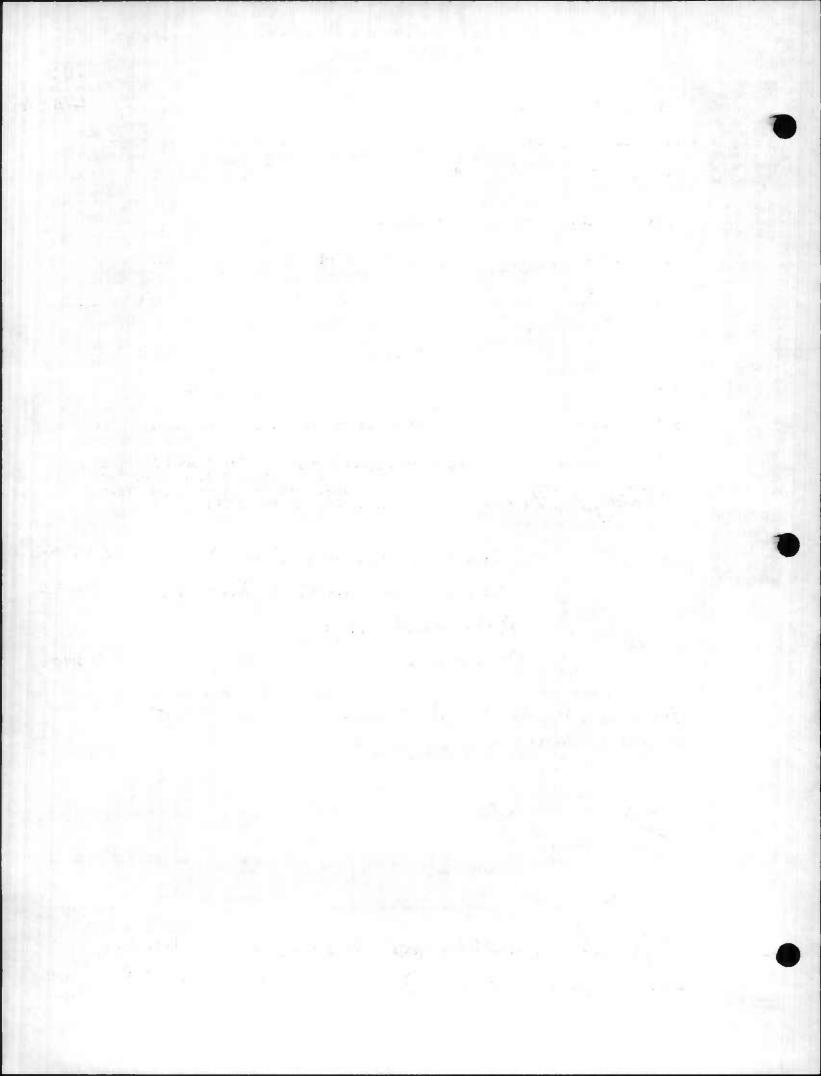
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month **Physician** MILDA ULIS 4.40 M 01 14 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funerai 1□M 2⊠F Deys Hours Yrs. 92 1906 577-48-3707 Director Latvia Usual Residence of Decedent 10e. Stete 10b. County r than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No N/A Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7509 8th Street, N.W. 20012 Funerai Latvia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Be Compieted by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Clothing permit. Pages 1 and 2 should be filed Department of Health and Mentel Hyg Important: If item 27 is marked other any Injury or other traumatic event, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Peter Zirnis Matilda Jansons 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Emils W. Ulis 7509 8th Street, N.W., Washington, DC (husband) 20012 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/16/98 Rockville, MD Parklawn Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 trum ease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest re. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner PSIG Univary The law requires that the deeth certificate be executed the buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet Initiated events resulting in deeth) Lest ie to (or es e consequence of) P.O. Box 68760. dvance Due to (or es e consequence of): nenmania Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Arterio sclerotic Records, 24b. Were eutopsy findings eveilable prior to Diabets mellity 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital of or Attending Physician: efter deeth.

Director: After this certifice 25. Was cese referred to medice exeminer? Certification: To Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide in by 1 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital within 24 hours or To the Funeral Completely filled Hospital *Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of conflier 29c. License number 29d. Date signed (Month, Dey, Year) 14/08 MD. 10 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Bullian Are # 509 College Pa ARVIND 7(00 MEHTA 31. Dete filed (Month, Day, Year)

JAN 1 5 32. Registrer's Signature
The Davidson Rands 12. Registrar



			Please 1	Type or Print in E State of Marylan	d / Depa		Health and	Mental Hygi	ene 98	ble.	1990		
п	1,200		1. Decedent's Nama (First, Middle, Las				3. Time of Deeth						
ı	Physic /Medi		RICH	HARD F.	WORK	MAN		January	^{Day} , 19	98	2:45pm		
	Exami		4a. Fecility Neme (If not institution, give streat end number) The Memorial Hospital Easton					Location of Deeth	4c. County Talbo				
	Funeral Director		5. Social Security Numbar 6. Security Numbar 216-76-8994 2 Usuel Residence of Decadent	7. Age (In yrs.	V-	If Undar 1 Yea Months Dey				9. Birthple Counti			
	the Marylan	Director		. WORCESTER BERLIN							d. Insida City Limits 1 Yes 2 No		
	3a or												
020	d within 72 hours effer death with the Maryland liene. I than "natural", or items 23s or 28s-1 show the Medical Examinal must be notified at	by Funerai	11. Maritel Status 15 Navar Married 2 Married 3 Widowed 4 Divorced				Hispenic Origin? (Suban, Mexican, Puer	pecify Yas or No- b Rican, etc.) 14. Raca - Bleck, Specify:		k, White, e	- American Indian, , White, etc.		
21215-0020	5 13	Completed	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give k	O NOT use reti	e during most of wa	rking 1	16b. Kind of Business/Industry				
	e filed with al Hygiene. other than		17. Fether's Neme (First, Middle, Last)		HOME	18 Mothar's Na	me (First, Middle, M	OW I		HOME			
lan	should be nd Mental marked o	To Be						TE HELMICK					
, Maryland	nd 2 shu lith end 27 is m r traum		19a. Informant's Neme/Relationship (7) CHARLES F. WO	ype, Print) RKMAN					al Route Number, City or Town, Stete, Zip Code) BERLIN, MD., 21811				
altimore,	ages ant of nt: If it		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specify,	Removal from State	emetery, crem	ition (Neme of etory or other p		Date 2	Oc. Location -				
Balti	permit. Pa Departmen Important: any Injury once.		21. Signeture of Fundral Service License		22.	Name and Add			BERLI		D., 2181		
, 0	Physician bushician bushician street physician and physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street	al Examiner	shock, or heart failure. List only of Immediate Cause (Final diseasa or condition resulting In deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (o	r es e consequ	ence of):	ree				Interval Between Onset end Daath		
Box 6876	ding iding	n/Medical	resulting in deeth) Last Due to (or as a consequence of): d.										
Vital Records, P.O.	the d	by Physician/M	Part II. Other eignificant conditions con	23b. Did tobacco use contribute to the cause of o									
	Physician: The law requires that this certificate has been signed that director, page 2 should be detent	Completed b						24a. Wes en perform	eutopsy ed?	evei	re eutopsy findings leble prior to spletion of causa eeth?		
		To Be	05 Mr					1 ☐ Yes		10	Yes 2 No		
			25. Was case referred to medical examiner?	lospitel: 1 ☐ Inpatient 2	ER/Outpetient	3□ DOA C	other	eth <i>(Check only one</i> Home 5□ Rasider		er (Specify)			
Division of	Attending Ph or death. ector: After thi by the funeral		27. Manner of Deeth 1 CNeturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c. Injury et 28d. Describe how Injury								
Divis	Hospital or Attend 24 hours efter deatl Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					
	To the Hospital or Attending Ph Within Zahours effer death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only medical Examiner: On the best of my knowledge, deeth occurred at the time, dete end placa, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, dete end placa, end due to the ceusa(s) and mennar stated.										
	To the To the comple	M	29b. Signature and title of certifier	1			nse number 486 322		d. Data signed	/_ /			
		6	30. Name and address of person who co	empleted cause of death (Item	23e) (Type, P	rint)	PSP.	EASTO	n, //	10 21	1801		

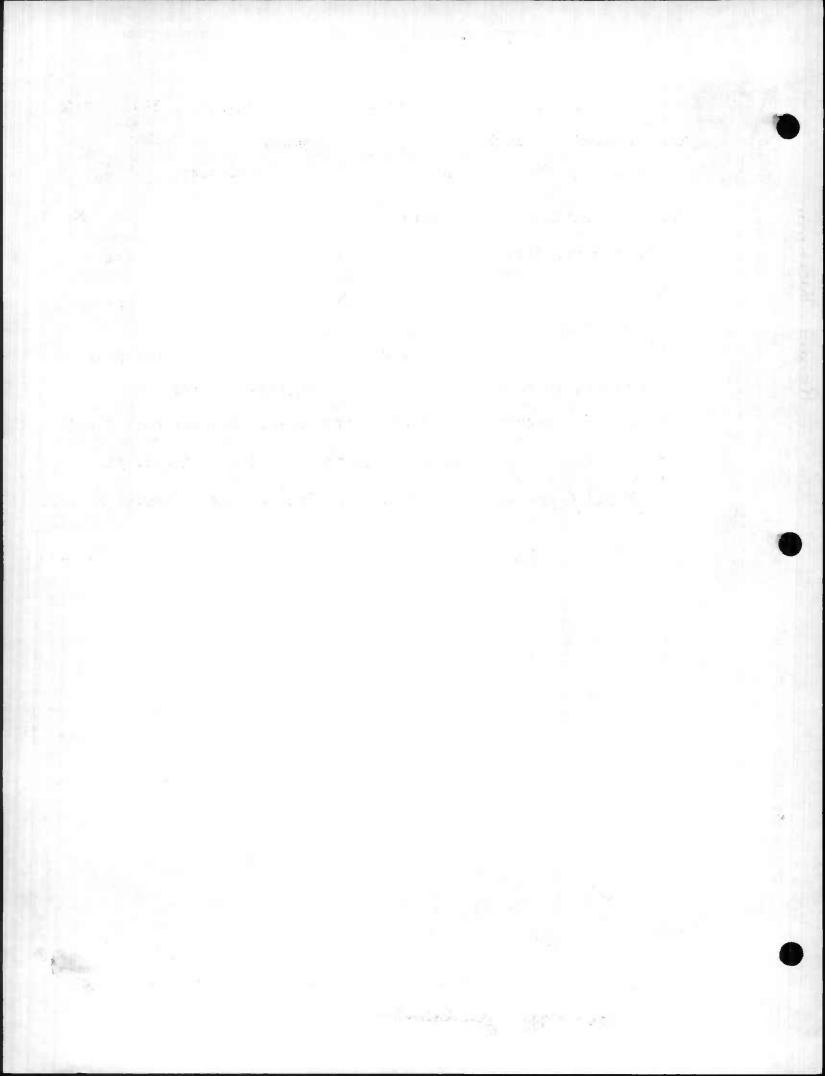
32. Registrer's Signeture

Julia Davidson-Rondolle

State Registrar

31. Dete filed (Month, Day, Yeer)

JAN 1 2 1998



Funeral Director 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within Depertment of Health end Mentel Hygiene. important: If flem 27 is merked other than any Injury or other trainment. **Physician** /Medical Examiner

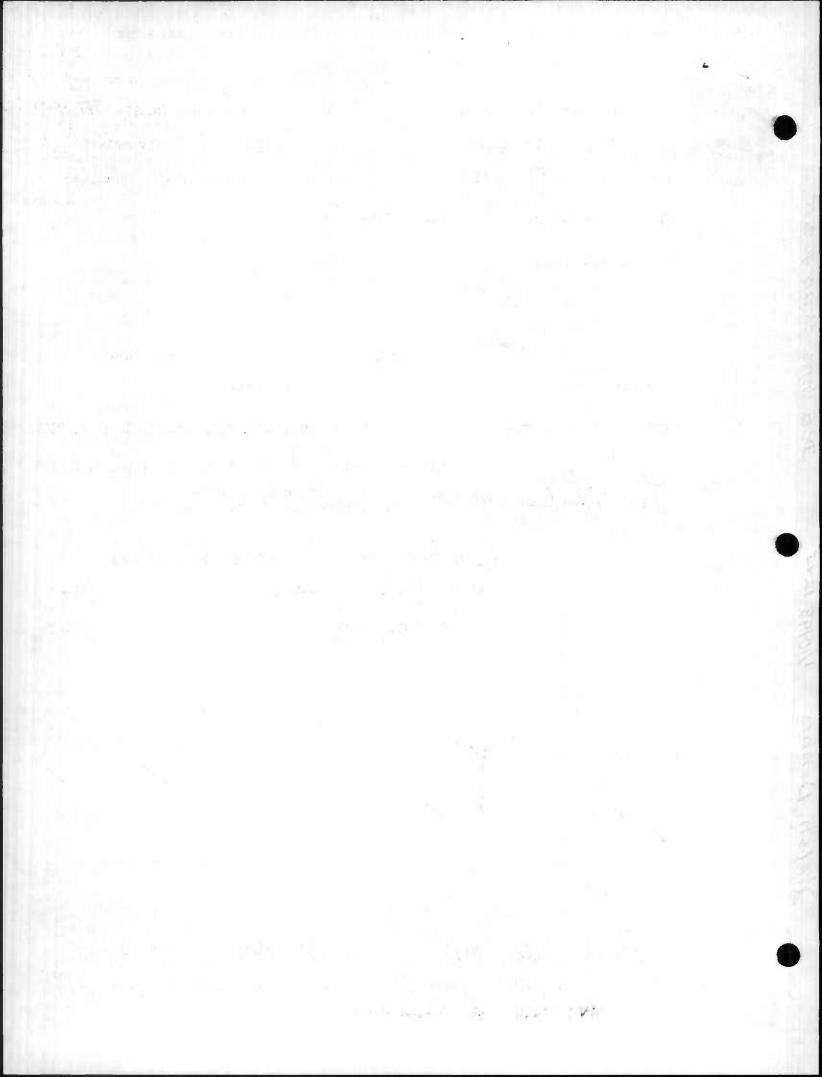
physician end s the burial-transit á Records, certificate Division of Vital this After death. Director: e Hospital or Att 24 hours efter d e Funeral Direct

Physician Month Year 12:45 PM DENNIS M. WALSH JANUARY 10,1998 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Yrs 218-46-7245 51 Jan. 18,1946 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Md. Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 4503 Atlantic Ave. 14. Race - American Indian, Black, White, etc. 21842 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married white 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Condominium 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernon Walsh Rita Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4503 Atlantic Ave., Unit 203, Ocean City, Md. 21842 ce of Disposition (Name of Date 20c. Location - City or Town, State Darla M. Walsh (wife) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 1-12-98 Frankford, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home, 231 Fart Enter, the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acrosic Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 No 25. Was cese referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homlcide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year)

State

within 2 To the F



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day LEROY JANUARY 11,1998 0250 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country)
 A • 18M 2 F Deys 85 192039293 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No SELBYVILLE DEL. SUSSEX 10e. Sfreef end Number 10f. Zip Code 10g. Citizen of What Country? 22 WILLIAM STREET 19975 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ANO Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RETAIL FOOD STORE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MD, 20874 13271 COUNTRY RIDGE RD., THOMAS R. WELD GERMANTOWN, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dafe 20c. Location - City or Town, Stefe 1 ☐ Burial 20x1Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 1-12 SALISBURY, MD. 21. Signature Filmonia 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, 23a. Part. Enter the disease, or complications that caused the death. Do not enfer the mode of dying, such as cerdiac or respiretory arrest, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Failure IWK Due to (or as a consequence of): IWK Sepsis Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury thef initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other aignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 No 1 ☐ Yes 2000 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Panpatient 2 ER/Outpatient 3 DOA 1 Yes 2 ₩o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homleide

The law requires that the death certificate be executed Box 68760 P.O. 1 Division of Vital Records. Attending Physician: ir death.

Examiner use as the burial-tran signed by the attending physician d be detached for use as tha buria Physician/Medicai þ Completed peen After this certificata Be P Certification: ours after dean of Director: An in by the fur-To the Hospital c within 24 hours af To the Funeral D complataly filled i

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th and Mantal Hygiana. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mantal Hygiana. Important: if item 27 is marked other than "natu any injury or other traumatic event, the inserted once.

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Dec 3-9293 Maryland

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Baltimore,

(Check only one 296. Signature and

29a. Certifier

Medical

State Registrar

My.

10 Certifying Physician: To the best of my knowledge, death occurred af the time, date and place, and due to the cause(s) end manner as stated.

2 Medicef Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number

450497

29d. Date signed (Month, Day, Year)

1/11/48

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) hRIS DNYNER 208 Pine

31. Date filed (Month, Dey, Year)

JAN 1 2 1998

Jalisbury, Md. 21801 32. Registrer's Signature

Gulia Davidson-Rondon

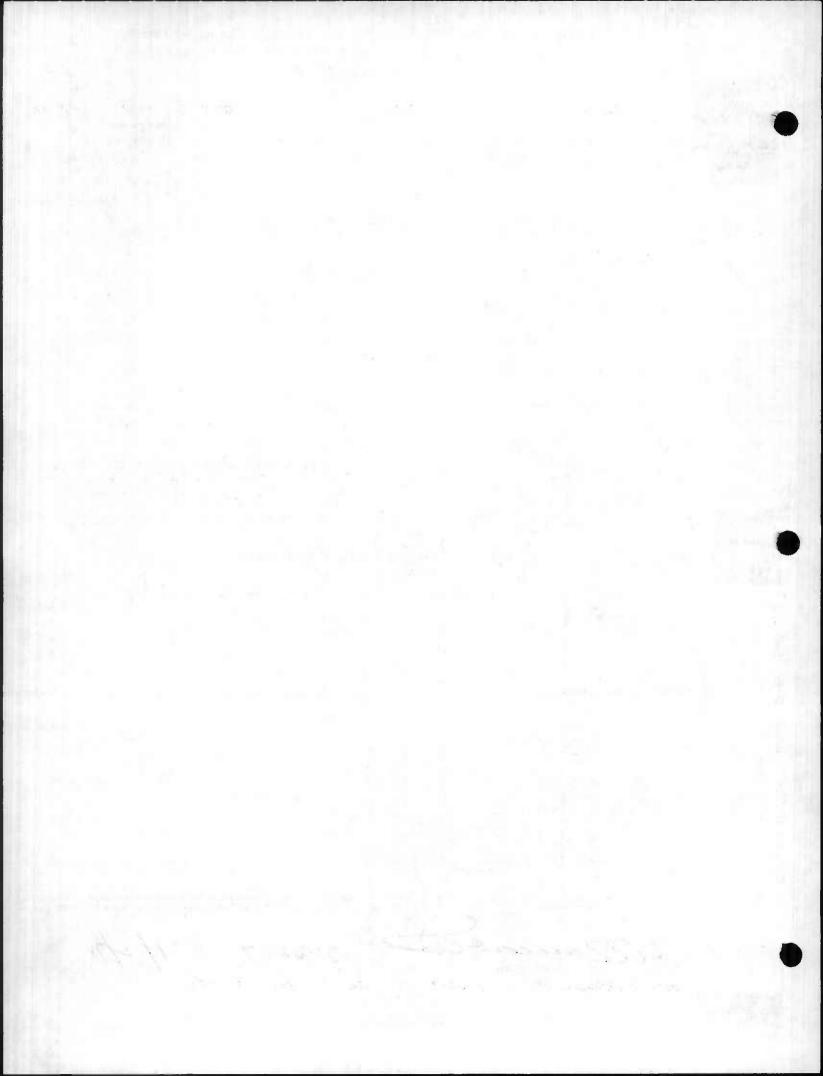
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month LUCILLE WEIGEL JANUARY 13 1998 2:35 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Daath **Examiner** Berlin Nursing Home Berlin. Worcester 5. Social Sacurity Number if Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Nov. 30, 1 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign Country) Virginia **Funeral** Days Hours 1 □ M 2 13 F Yrs. 578-24-8788 99 Director Nov. 1898 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 ☑ No Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20852 Funeral 14635 Bauer Drive IISA death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. Important: if item 27 is merked other than "netural", or item any injury or other traumatic event, the Medical Exercises. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White py Specify 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetologist Beauty 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be John McPherson Gertrude Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Code) (daughter) 146 Georgia Avenue, Ocean City, MD Anita Louizes 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/16/98 Falls Church, Virginia National Memorial Park 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21 Signature of Funaral Sarvice Licensee Home, Inc. Silver Spring, MD 20901 even ronc 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwe **Physician** Onsat and Death Immediata Causa (Final disaasa or condition rasulting In daath) /Medical NEBROVASCULAR Examiner Physician/Medical Examiner EROSCUEROTIR The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): use es the bunel-tre P.O. Box 68760, physician Dua to (or as a consequence of): for ate hes been signed by the page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of ceusa of death? certificate hes 1 Yes 2 XNo 1 Yas X No or Attending Physician: Be 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Check only ona) Other: 4 🗖 Nursing Homa 5 🗆 Rasidance 6 🗆 Other (Specify) Certification: To 1 Yes 2 XNo 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours effer deeth.
To the Funeral Director: After To the funeral birector of the funera 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.

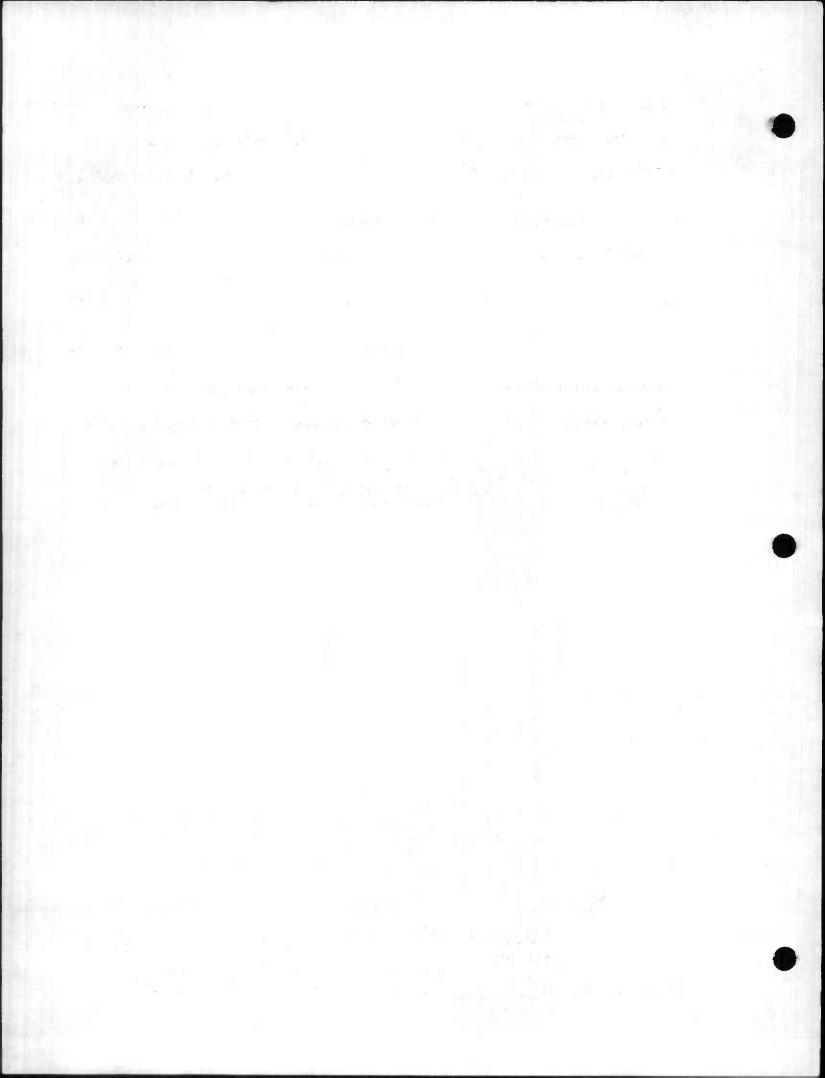
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| Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and dua to the causa(s) and mannar stated. Medicai 29a. Certifian (Check only one) 29b. Signature and titla of certifier 29c. Licansa numbar 29d. Date signed, (Month, Day, Year) 30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print) 314 FRANKLIN AVE, STE 103, BERLIN, MD 21811 EDWIN CASTANEDA, MD 31. Data filed (Month, Day, Yaar) 32. Ragistrar's Signatura JAN 15 Registrar La Davidson



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a	4	21. Signature of Fundral Service Licenses All Neme end Address of Fecility Ines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD													
		23a Part / Enter the disease or complications that causind the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Intervel Between Onset and Death											mete Between nd Deeth		
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	Š P	25. Was case referred to medi	cal						28. Place	of Death	1 Check only		11	□ Yes	2□ No
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		27. Manner of Death 1 Neturei 5 ☐ Pen	ding	(Month, Day Year) Injury Work?						28d. Describe	how injury occu	irred			
	Certification:	3 Suicide 6 □ Cou	d not be mined	be con Place of John Athens for street feature Miles						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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			11 -				1 1	117) X //	7		7)]]] [199	X	
	-	30. Name and address of person	luysi	Clou	of death /item	23a) (Tyne 1	Print)	148	108C	7	CUA	ema N	199	8	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death WILSON **Physician** Month JANUARY 3:16 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Min. 1□M 2⊠F Yrs. Director 356-30-7684 87 Australia Usuai Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits ral', or itema 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Chevy Chase 10e. Street end Number 10f. Zlp Code 10g, Citizen of Whet Country? 5555 Friendship Boulevard 20815 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ Specify: White 3 ⊠ Widowed 4 □ Divorced Completed traumatic event, the Medical 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Homemaker Own Home 6 permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: if flem 27 Is marked other eny injury or other traumatic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Clarence Ainsworth Beatrice Alderson 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia A. O'Brien/ Daughter 10214 Democracy Blvd., Potomac, Maryland 20854 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Jan. 20 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signeture of Funeral San 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 100689 Bethesda, Maryland 20814-3501 liseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, illure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** RESPIRATORY ARREST /Medical immediete Ceuse (Final disease or condition resulting in death) Examiner PNE UMONIA Examiner Due to (or es e consequence of):
HRONIC BRONCHITIS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HRONIC OBSTRUCTIVE LUNG-DISEAS 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No HYPOTHYROLDISM 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Medical Certification: To 28a. Date of injury (Month, Dey Year) 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Tyes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29e. Certifier

P.O. Box 68760. To the Hospital within 24 hours a To the Funeral C completaly filled

the Maryland

death

e filed within 72 hours aftar al Hygiane. other than "netural", or ite

Baltimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Dey, Year)

29b. Signeture and title of certifier

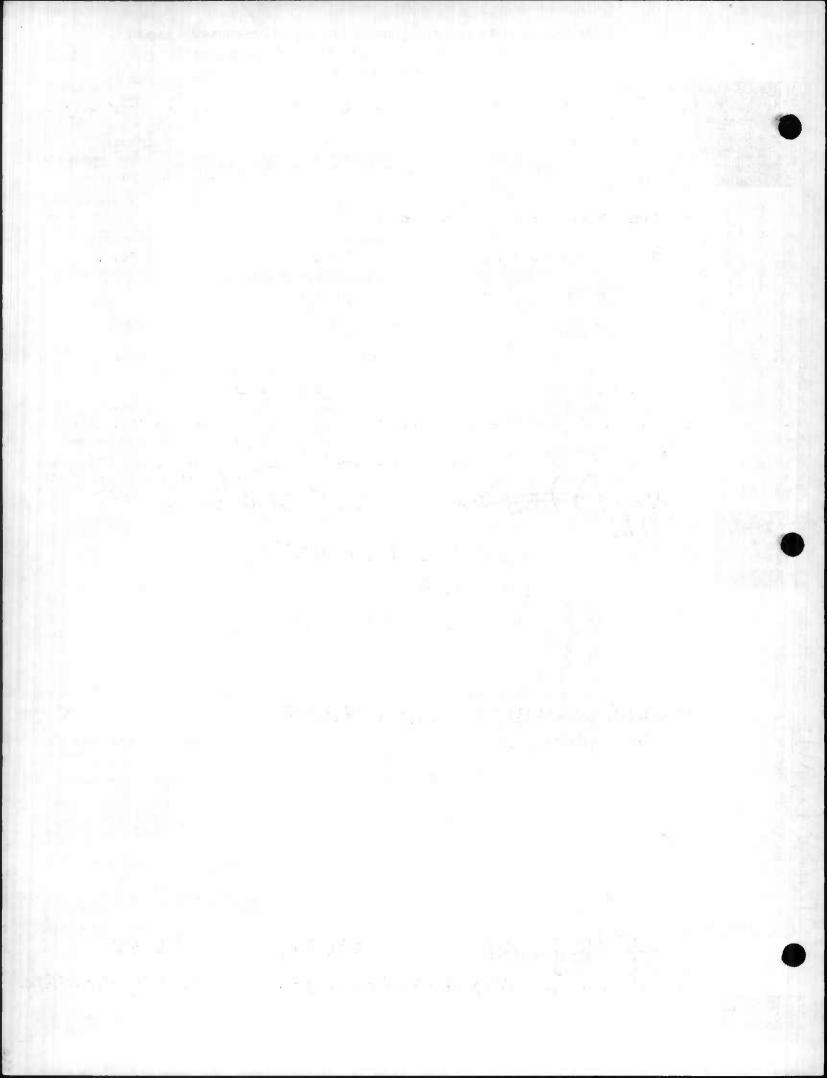
29c. License number

29d. Date signed (Month, Dey, Year)

ss of person who completed cause of deeth (item 23e) (Type, Print) 930 DEL RAY AVE. BETHESDA, MD 20814

DHMH 16 Rev 6/95

daath.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 7,1998 **Physician** Month 2:05pm January /Medical Wise Lawrence 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Mariner Health of Silver Spring Silver Spring Montgomery 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Dec. 25, 1909
Russia 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) 1XM 2□ F Deys Hours Yrs. 579-05-0583 88 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at Maryland Montgomery Silver Spring Director 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with or items 23a or 14508 Homecrest Rd. 20906 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondery (0-12) Butcher Retail Market other t 17. Father's Name (First, Middle, Lest) Be 18. Mother's Name (First, Middle, Meiden Sumeme) Department of Health end Mentel Important: If Item 27 Is marked o Jacob Wise Bessie Petergorsky 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 14508 Homecrest Rd. Silver Spring, MD 20906 Annetta Wise/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete N☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete King David Mem. Gdns. 1/9/98 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature & Funeral Service Licer 22. Name end Address of Eacility Funeral Homes 0 2847 Wilson Blvd. Arlington, VA 22201 23a. Part 1. Enter the disease, ox complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical Pneumonia 5 days **Examiner** Due to (or es e consequenca of): Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Bnd Due to (or es e consequence of): bund Division of Vital Records, P.O. Box 68760. physician s the buriel Physician/Medical Due to (or es e consequence of): onding p foru signed by the a Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown p Completed 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? page 2 s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐XNo or Attending Physician: 25. Wes cese referred to medical exeminer? director. Be 28. Place of Deeth (Check only one) Other: 4 💆 Nursing Home 5 🗆 Residence 8 🗆 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No this 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Netural s after deeth. 1 Yes 2 No 2 Accident the 8 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) À 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral C completely filled 29a. Certifier 1 Note that the best of my knowledge, deeth occurred et the time, date end pieca, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end pieca, end due to the cause(s) end menner steted. Medicai (Check only one)

State Registrar 31. Dete filed (Month, Day, Year) JAN 14 1998

29b. Signeture end title of cartifier

32. Registrer's Signeture

30. Neme end address of person who completed cause of death (ttem 23e) (Type, Print)

Via Davidson

29c. License number

D09834

Barry N. Rosenbaum, M.D. 3720 Farragut Ave. Kensington, MD 20895-2110

29d. Date signed (Month, Day, Year)

1/7/98

PH Kenelle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Death 1998 AROL 8:23pm bruary 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath, 4c. County of Deeth Hospital Southern Maryland Clinton Prince George's If Undar 1 Year 5. Sociel Sacurity Numbar 8. Date of Birth (Month, Dev. Year) September 5, 7. Age (In yrs. lest birthday) If Undar 24 Hrs. 9. Birthplece (State or Foreign Deys Min. Months Hours 578-76-8888 1□ M 2√0 F 43 1954 Maryland Vrs Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Clinton ty Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7802 Marwood Drive 20735 USA 11. Marital Status 12. Was Dacadent Evar In U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indien, Black, White, etc. 1 ☐ Naver Merried 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yas, Give Yeer or Dates: 1 ☐ Yas 2 No Specify: 3 □ Widowed 4 ₺ Divorced Black 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Surneme) George Tittle Myrna Choates 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna Choates/Mother 7802 Marwood Drive Clinton, Maryland 20735 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State ₩ Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery January 13, 1998 Clinton, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility 20608 Adams Funeral Home 20605 Aquasco Road Aquasco, Maryland 23a. Pert1. Enter the disasse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Finel 1 week diseesa or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): years the Circhosis of Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Syndrome 2 Weeks Hepato penal 24b. Were eutopsy findings eveilabla prior to completion of ceusa of deeth? 24e. Was an eutopsy performed? 1 ☐ Yes 2 ☐ NA 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

and

Physician

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

Be

2

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, he Medical Examinal must be notified at

the Maryland

death

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Be Completed

The law requires that the death certificate be executed burial-trensit P.O. Box 68760. physician use as the ettending Po à Records, peen page 2 s certificate has Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

25. Wes cese raferred to medical Certification: To 27. Menner of Death

Registrar

edicai

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or Investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending Investigation

6 Could not be determined

1 Yes 2 □X4c

1 Naturel

2 Accident

3 ☐ Suicide

4 Homicide

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 9131 Piscataway 1. Haye Rd

Clinton

1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work?

1 Yes 2 No

226352

29c. Licanse number

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

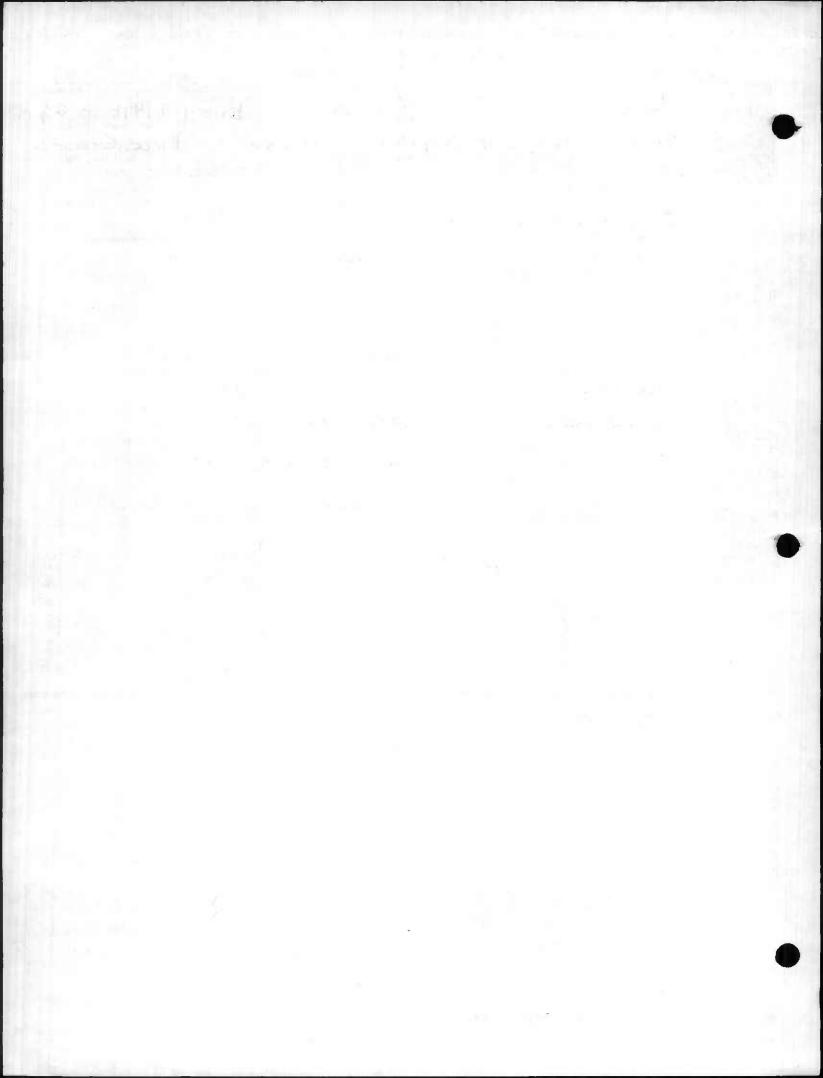
Location (Street end Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Dev. Year)

1999

31. Date filed (Month, Day, Year) 32. Registrer's Signature JAN12 Falia Stoodson Raylall 1998

28e. Date of Injury (Month, Dey Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month ANDERSON LESLIE 6.25 AM JEAN JANUARY 23 1998 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner n yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. D. Months Days Hours Min. 2000 -JAMARITAN 8. Dete of Birth (Month, Dey, Yeer)

NACH 5 1947 MARY LAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 200 F 215 46 8836 Usual Residence of Decedent Yrs. 50 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or ttema 23a or 28a-f shot traumatic event, the Madical Experies must be notified as 1 Yes 2N No Director JERYLAN HARFURD 10e. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? U.S.A 917 JOOUZZIL SOAO 21014 Funeral filed within 72 hours efter deeth 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 281 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: Completed by STIHW 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL 127RS. 3 YRS. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merked other ony injury or other traumetic avant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be SIEPHEN ICHOL F02051 IARY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21014 19a. Informant's Name/Relationship (Type, Print) K. Anorason MARYLAND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) AR DAVIO 20e. Method of Disposition Dete 20c. Location - City or Town, State LAG. DAL 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE 1 1AAVLAND MOUNT REMAIOR 1003 alura of Funeral Services 22. Name and Address of Fecility LAPPEL -BELRIR, P.A. NEWPORT ORIVE MARYLAM 23a. Pan1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause in each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final SEPSIS 42 DAYS disease or condition resulting in death) **Examiner** Due to (or as e consequence of): Examiner 42 DAYS CELLULITIS The law requires that the death certificate be executed bunial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, physiclen Physician/Medical the Due to (or es e consequence of): ed by the atten Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 3 Unknown METASTATIC ADENOCARCINOMA ate hes been signed page 2 should be det Records, þ Be Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? VASCULITIS ASPERGILLUS INFECTION AND After this certificate hes ATYPICAL MYCOBACTERIAL 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No INFECTION Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ⊠ Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No s efter death 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical To the To the To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Thromas MD P10582 JANUARY 23, 1998.

5601, LOCH RAVEN BLUD, BALTIMORE, MD- 21239.

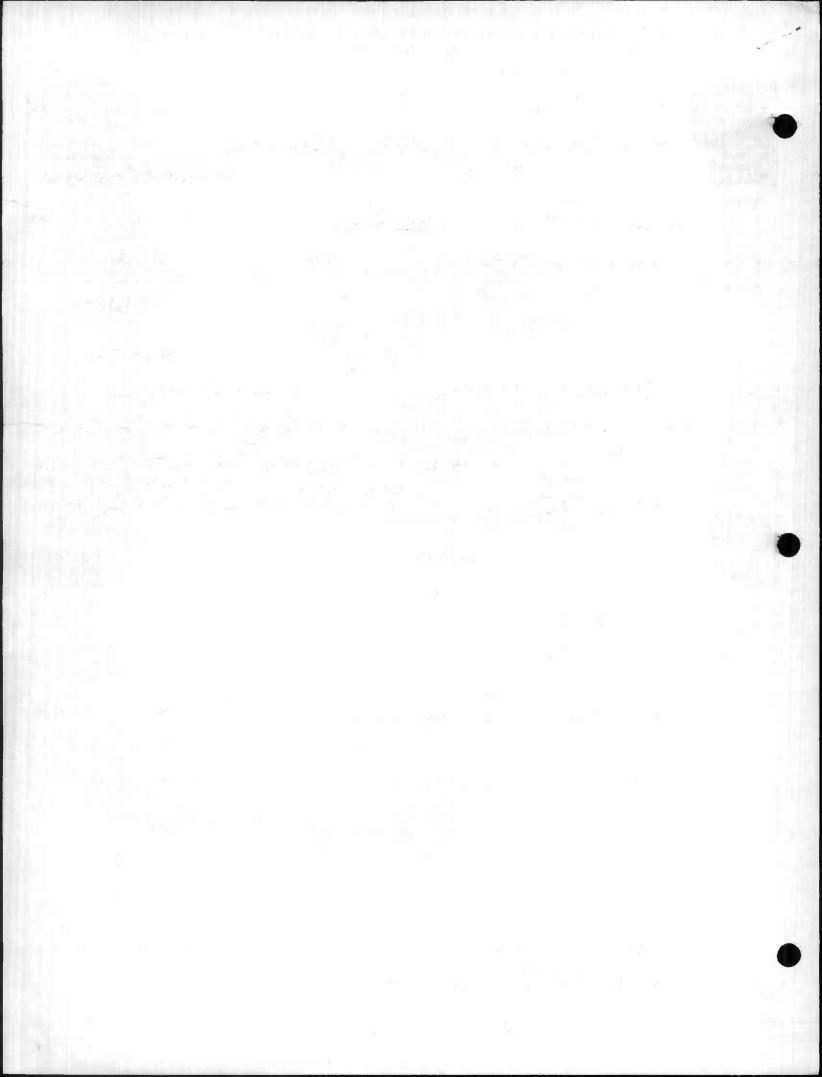
State Registrar 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature

MECHERIKUNNEL

31. Dete fiel Month Day 9 9

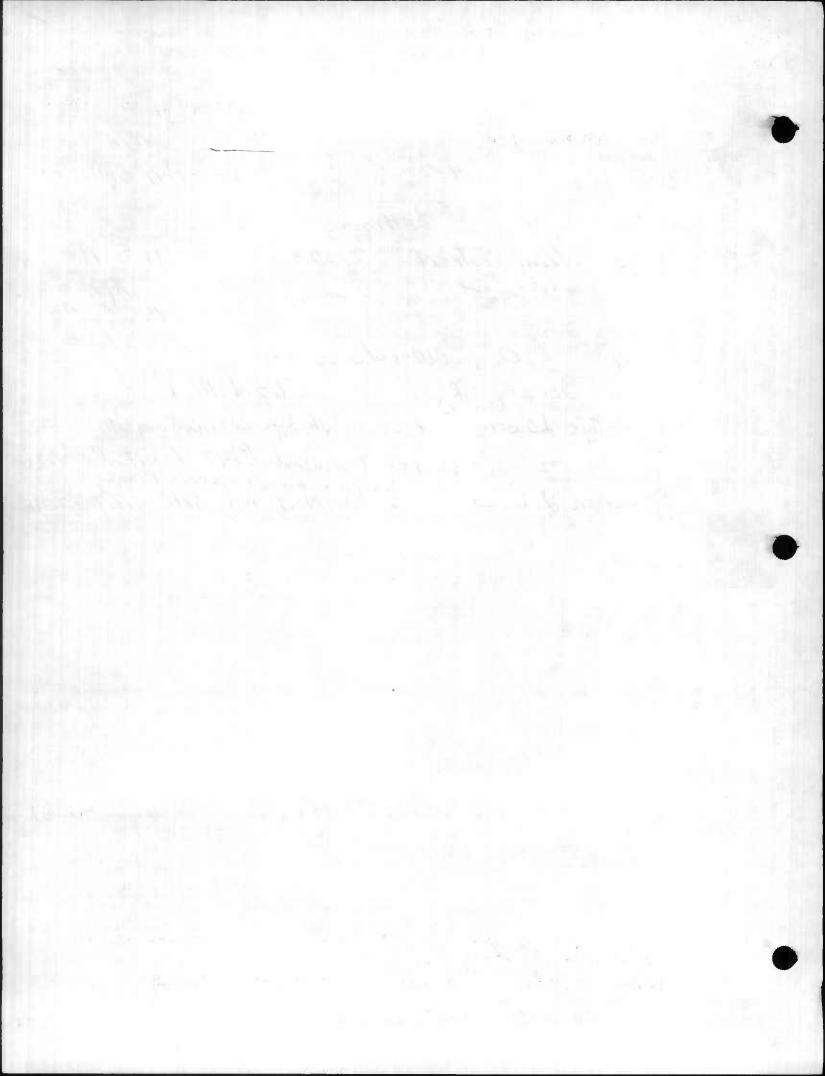
DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 23a part I, 27, 28a-f per MEO G-755 1/28/98 dh 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 7:02 AM 14, JANUARY 1998 CON 1200ZE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner FREEDOMWAY BALTIMORE 1819 NORTH If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foraign 8 **Funeral** Months Deys Hours 1 X M 2 □ F 19-52-9506 Yrs. Director Usual Residence of Decedent the Meryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at 1 Tes 2 No Directo 10e. Street end Number more 10f. Zip Code 10g. Citizen of What Country? with 6 r than "natural", or items 23a or the Medical Examiner must be 2533 122 3 2 Funeral deeth 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 4 Bace - American Indien Black, White, etc. ned within 72 hours after 1 Never Married 2 Married 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Yes 2 No Spacify: þ 3 ☐ Widowed 4 ☐ Divorced EVICAN Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast grede completed) Elementary/Secondary (0-12) Eurnilur College (1-4or 5+) Hyllene. NATEROUSE man 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symeme) Be ed pinous and Mental marked c 0002e 11 194. Informant's Name (Helationship (Type, Print) (5/5/e) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State/Zip Code) Hem 27 i 4004 Mrs. Belly Baltimore, 20b. Placa of Disposition camatery, cremator 20c. Location - City or Town, Stata 20a. Method of Disposition Pages b important: If it any injury or o 1 EBurial 2 Cremation 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) A110 22. Name and Address of Pacific Joseph L. Wor, 22 22 W. Nor, 21. Signature of Funeral Service Licensee md.21216 nease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximeta Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical NARCOTIC INTOXICATION Examiner Due to (or as a consequence of): Examine end I-transit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physicien er s the burial-t Physician/Medicai Due to (or as a consequenca of) ettending f signed by the e Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Wara autopsy findings avellable prior to completion of cause of deeth? been signated 24e. Was an autopsy performed? Completed s certificate hes b director, page 2 s 1 Yes 2 - No 25. Was case referred to medical axaminar?
1 ☐ Yes 2 ☐ No
27. Manner of Death director, or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Mother (Specify) Triend's head Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28b. Time of Injury 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? A 5 Pending 1 Natural 1 Yes 2 No deeth. investigation efter deeth Director: A d in by the f 2 Accident found 6:30 found 1/14/98 6 XX could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1819 Freedomway North, 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire completely filled in b found in a residence Baltimore, Md. Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end manner stated. To the Vithin 2 29b. Signature and title of cartifier 29c. Licensa number 29d. Data signed (Month, Day, Yaer) JANUARY 14, 1998 O.C.M.E. 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture Pulia Davidson-Randall JAN 28 1998 Registrar

DHMH 16 Rev 6/95



HOSPITAL

32 Projetrar's Signature

7. Age (In yrs. last birthday)

61

Yrs.

	t in Black Indelible Ink. Assure	-	_		
State of Ma Item#7.#8 per FH G756 2/3/98 EW	ryland / Department of Health and Certificate of Death		ene	0.	2000
Physician /Medical GLENN C. Bowman		2. Date of Deeth Month	Day 23	Year 98	3. Time of Death
Yaminer 4e. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	4c. Count	v of Death	

Days

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

4c. County of Death

HONARD

Birthplace (State or Foreign Country)

Ohio

8. Date of Birth (Month, Day, Year)1935

Funeral Director

Physician

Examiner

190-28-0759

1 M 2 □ F

5. Social Security Number 6. Sex

death with the Maryland ir than "natural", or items 23s or 28s-f show the Medical Exercines must be notified at

Director Howard Md. 10e. Street and Number 4817 Hale Haven Drive 12. Was Decadent Ever in U,S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Yeer or Dates: 1955-58 11. Marital Status 1 ☐ Never Married 2 ☐ Married filed within 72 hours efter altimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 or other traumatic event. 17. Father's Name (First, Middle, Last) Be permit. Peges 1 and 2 should be Depertment of Health and Mentel important: If Itam 27 is merked o any Injury or other traumatic eve Glenn Robert Bowman 19e. Informant's Name/Reletionship (Type, Print) Lucille Bowman – wife 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service License Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner NEWMONIA es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest and be exec Box 68760. nding physician WIDESPREAD Physician/Medical P.O. | Division of Vital Records. by been signal Completed or Attending Physician: 25. Was case referred to medical examiner? Be 1 Yes 2 No Hospital: P within 24 hours effer death.

To the Funeral Director: Affer this completely filled in by the funeral di 27. Menner of Death 1 ■Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide the Hospital Medicai 29a. Certifier (Check only one) 29b. Signature and title of certiful 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mo H T BHAWALL 34 (OLMDER)

31. Date filed (Month, Day, Year)

28 1998

JAN

JUNE 6, 1938 Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Ellicott City 10g. Citizen of What Country? 10f. Zip Code 21043 USA Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 1 ☐ Yes 2 ☐ No Specify: Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Audio Engineer **CBS** 18. Mother's Name (First, Middle, Maiden Surname) Edna Mahlig 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4817 Hale Haven Dr., Ellicott City, Md. 2104
a of Disposition (Name of Date 20c. Location - City or Town, State 21043 20b. Placa of Disposition (Name of cametery, crematory or other place) 1/26/98 Marriottsville, Md. Crest Lawn Memorial Grdns. 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death KESPIRATORY FAILURE Due to (or as a consequenca of): MULTIPLE MYELOMA Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) JAN 23, 1998 3414 OLANDWOOD GT., OLNEY, MD 20532

State

Registrar

